

EXHIBIT 3

Page 1

1 UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF NEW JERSEY
3 CAMDEN VICINAGE

4 IN RE: VALSARTAN, LOSARTAN, AND) MDL No. 2875
5 IRBESARTAN PRODUCTS LIABILITY)
6 LITIGATION)
7

8 VIDEOTAPED DEPOSITION OF:

9 EDWARD H. KAPLAN, M.D.

10 WEDNESDAY, JANUARY 19, 2022

11 9:14 a.m. Central Standard Time
12

13 TRANSCRIPT of the stenographic notes of the
14 proceedings in the above-entitled matter as taken by and
15 before KELLY A. BRICHETTO, a Certified Court Reporter of
16 the State of Illinois, held at 77 West Wacker Drive,
17 Suite 3100, Chicago, Illinois, on Wednesday, January 19,
18 2022, commencing at approximately 9:14 a.m. pursuant to
19 notice.
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22
23
24

<p style="text-align: right;">Page 2</p> <p>1 A P P E A R A N C E S:</p> <p>2 On behalf of the Plaintiffs:</p> <p>3 RACHEL J. GEMAN (In person)</p> <p>4 LIEFF CABRASER HEIMANN & BERNSTEIN</p> <p>5 250 Hudson Street</p> <p>6 8th Floor</p> <p>7 New York, New York 10013</p> <p>8 (212) 355-9500</p> <p>9 rgeman@lchb.com</p> <p>10</p> <p>11 On behalf of the Plaintiffs:</p> <p>12 NICHOLAS A. MIGLIACCIO (Via Zoom)</p> <p>13 MIGLIACCIO & RATHOD, LLP</p> <p>14 412 H Street NE</p> <p>15 Suite 302</p> <p>16 Washington, D.C. 20002</p> <p>17 (202) 470-3520</p> <p>18 nmigliaccio@classlawdc.com</p> <p>19</p> <p>20 On behalf of the Plaintiffs Executive</p> <p>21 Committee:</p> <p>22 BRETT VAUGHN (Via Zoom)</p> <p>23 HOLLIS LAW FIRM</p> <p>24 8101 College Boulevard</p> <p>Suite 260</p> <p>Overland Park, Kansas 66210</p> <p>(913) 385-5400</p> <p>brett@hollislawfirm.com</p> <p>On behalf of the Brown Plaintiff:</p> <p>DANIEL NIGH (Via Zoom)</p> <p>LEVIN PAPANTONIO THOMAS MITCHELL</p> <p>RAFFERTY & PROCTOR, PA</p> <p>316 South Baylen Street</p> <p>Suite 600</p> <p>Pensacola, Florida 32501</p>	<p style="text-align: right;">Page 4</p> <p>1 On behalf of the Defendant Express</p> <p>2 Scripts:</p> <p>3 JAMES SPUNG (Via Zoom)</p> <p>4 HUSCH BLACKWELL, LLP</p> <p>5 736 Georgia Avenue</p> <p>6 Suite 300</p> <p>7 Chattanooga, Tennessee 37402</p> <p>8 (423) 755-2652</p> <p>9 James.Spung@huschblackwell.com</p> <p>10</p> <p>11 On behalf of the Defendant Sciegen</p> <p>12 Pharmaceuticals:</p> <p>13 GEOFFREY M. COAN (Via Zoom)</p> <p>14 HINSHAW & CULBERTSON, LLP</p> <p>15 53 State Street</p> <p>16 27th Floor</p> <p>17 Boston, Massachusetts 02109</p> <p>18 (617) 213-7045</p> <p>19 GCoan@hinshawlaw.com</p> <p>20 On behalf of the Defendants Zhejiang Huahai</p> <p>21 Pharmaceutical Co., Ltd., Princeton</p> <p>22 Pharmaceutical, Inc. and Solco Healthcare US,</p> <p>23 LLC:</p> <p>24</p> <p>ALYSON LOTMAN (Via Zoom)</p> <p>DUANE MORRIS, LLP</p> <p>30 South 17th Street</p> <p>Philadelphia, Pennsylvania 19103</p> <p>(215) 979-1177</p> <p>ALotman@duanemorris.com</p> <p>On behalf of Mylan Laboratories, Ltd. and</p> <p>Mylan Pharmaceuticals, Inc.:</p> <p>PIETRAGALLO GORDON ALFANO BOSICK &</p> <p>RASPANTI, LLP</p> <p>FRANK STOY (Via Zoom)</p> <p>JASON REEFER</p> <p>301 Grant Street</p> <p>38th Floor</p> <p>One Oxford Centre</p> <p>Pittsburgh, Pennsylvania 15219</p> <p>fhs@pietragallo.com</p>
<p style="text-align: right;">Page 3</p> <p>1 On behalf of the Defendant Camber</p> <p>2 Pharmaceuticals, Inc.:</p> <p>3 ANDREW ALBERTO (Via Zoom)</p> <p>4 LEWIS BRISBOIS</p> <p>5 550 East Swedesford Road</p> <p>6 Suite 270</p> <p>7 Wayne, Pennsylvania 19087</p> <p>8 (215) 977-4058</p> <p>9 Andrew.Alberto@lewisbrisbois.com.</p> <p>10</p> <p>11 On behalf of the Defendant Teva</p> <p>12 Pharmaceuticals USA, Inc.:</p> <p>13 GLENN S. KERNER (In person)</p> <p>14 NILDA ISIDRO (In person)</p> <p>15 GREENBERG TRAURIG, LLP</p> <p>16 One Vanderbilt Avenue</p> <p>17 New York, New York 10017</p> <p>18 (212) 801-9200</p> <p>19 kernerg@gtlaw.com</p> <p>20 isidron@gtlaw.com</p> <p>21</p> <p>22 On behalf of the Defendant Teva</p> <p>23 Pharmaceuticals USA, Inc.:</p> <p>24 KATE WITTLAKE (Via Zoom)</p> <p>GREENBERG TRAURIG, LLP</p> <p>Terminus 200</p> <p>3333 Piedmont Road NE</p> <p>Suite 2500</p> <p>Atlanta, Georgia 30305</p> <p>wittlakek@gtlaw.com</p> <p>On behalf of the Defendant McKesson</p> <p>Corporation:</p> <p>ELLIE NORRIS (Via Zoom)</p> <p>D'LES LI DAVIS (Via Zoom)</p> <p>NORTON ROSE FULBRIGHT, LLP</p> <p>2200 Ross Avenue</p> <p>Suite 3600</p> <p>Dallas, Texas 75201</p> <p>(214) 855-8000</p> <p>ellie.norris@nortonrosefulbright.com</p> <p>dlesli.davis@nortonrosefulbright.com</p>	<p style="text-align: right;">Page 5</p> <p>1 On behalf of the Defendant Amerisource Bergen:</p> <p>2 JEFF D. GEOPPINGER (Via Zoom)</p> <p>3 ULMER & BERNE, LLP</p> <p>4 600 Vine Street</p> <p>5 Suite 2800</p> <p>6 Cincinnati, Ohio 45202</p> <p>7 (513) 698-5000</p> <p>8 jgeoppinger@ulmer.com</p> <p>9</p> <p>10 On behalf of the Defendant CVS Pharmacy, Inc.</p> <p>11 and Rite Aid Corporation:</p> <p>12 MITCHELL CHARCHALIS (Via Zoom)</p> <p>13 BARNES & THORNBURG</p> <p>14 2029 Century Park East</p> <p>15 Suite 300</p> <p>16 Los Angeles, California 90067</p> <p>17 mcharchalis@btlaw.com.</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>ALSO PRESENT:</p> <p>BEN PELTA-HELLER, Videographer</p> <p>SCOTT ZIARKO, Videographer</p>

<p style="text-align: right;">Page 6</p> <p>1 TRANSCRIPT INDEX</p> <p>2 APPEARANCES 2</p> <p>3</p> <p>4 INDEX OF EXHIBITS 4</p> <p>5</p> <p>6 EXAMINATION OF EDWARD H. KAPLAN, M.D.</p> <p>7 BY MR. KERNER 11</p> <p>8 BY MS. LOTMAN 107</p> <p>9 BY MR. KERNER 115</p> <p>10 BY MR. GEOPPINGER 121</p> <p>11 BY MS. LOTMAN 126</p> <p>12 BY MS. GEMAN 128</p> <p>13</p> <p>14 REPORTER'S CERTIFICATE 131</p> <p>15</p> <p>16</p> <p>17 EXHIBIT CUSTODY</p> <p>18 COURT REPORTER</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>	<p style="text-align: right;">Page 8</p> <p>1 THE VIDEOGRAPHER: Good morning. We are now</p> <p>2 on the record. My name is Scott Ziarko. I'm the</p> <p>3 videographer representing Veritext Legal Solutions.</p> <p>4 Today's date is January 19th, 2022. The</p> <p>5 time is approximately 9:14 a.m. This deposition is being</p> <p>6 held at 77 West Wacker Drive in Chicago, Illinois as well</p> <p>7 as by Zoom meetings in the matter of In Re: Valsartan,</p> <p>8 Losartan, et al. The name of the witness is Edward H.</p> <p>9 Kaplan, M.D.</p> <p>10 Our court reporter is Kelly Brichetto who</p> <p>11 is also with Veritext Legal Solutions.</p> <p>12 All counsel will be noted in the written</p> <p>13 record.</p> <p>14 Would the court reporter please swear in</p> <p>15 the witness.</p> <p>16 (Witness sworn.)</p> <p>17 You may begin.</p> <p>18 MR. KERNER: Before we get started, Scott, can</p> <p>19 we move the video camera just a touch to get the laptops</p> <p>20 out of the screen since I can't get any closer?</p> <p>21 THE VIDEOGRAPHER: There you go.</p> <p>22 MR. KERNER: Great.</p> <p>23 THE WITNESS: And I have to look at myself.</p> <p>24 MS. GEMAN: I'm sorry. My pen literally just</p>
<p style="text-align: right;">Page 7</p> <p>1 INDEX OF EXHIBITS</p> <p>2 NUMBER DESCRIPTION IDENTIFIED</p> <p>3 Exhibit 1 Notice of Deposition 29</p> <p>4 Exhibit 2 Curriculum Vitae 37</p> <p>5 Exhibit 3 Report of Dr. Kaplan 44</p> <p>6 Exhibit 4 Thumb drive 104</p> <p>7 Exhibit 5 Dr. Kaplan's Invoices 115</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>	<p style="text-align: right;">Page 9</p> <p>1 died. Using the word literally correctly. Is there one</p> <p>2 back here?</p> <p>3 MR. KERNER: We're off to an auspicious</p> <p>4 beginning.</p> <p>5 MS. GEMAN: Indeed. I have others in my room.</p> <p>6 I can go get it.</p> <p>7 MR. KERNER: You need a pen?</p> <p>8 MS. GEMAN: I need a pen.</p> <p>9 MR. KERNER: Do we need this on video?</p> <p>10 THE VIDEOGRAPHER: Want to go off the record?</p> <p>11 MR. KERNER: Yeah, go off the record.</p> <p>12 THE VIDEOGRAPHER: The time is 9:15. We're</p> <p>13 off the record.</p> <p>14 (Discussion had off the</p> <p>15 record.)</p> <p>16 The time is 9:16 a.m. We're back on the</p> <p>17 record. This is media two.</p> <p>18 Will the court reporter please swear in</p> <p>19 the witness.</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>

<p style="text-align: right;">Page 10</p> <p>1 (Witness sworn.)</p> <p>2 WHEREUPON:</p> <p>3 EDWARD H. KAPLAN, M.D.,</p> <p>4 called as a witness herein, having been first duly sworn,</p> <p>5 was examined and testified as follows:</p> <p>6 DIRECT EXAMINATION</p> <p>7 BY MR. KERNER:</p> <p>8 Q. Good morning, Dr. Kaplan.</p> <p>9 A. Good morning.</p> <p>10 Q. My name is Glenn Kerner. We met a new</p> <p>11 minutes ago. I am an attorney representing Teva</p> <p>12 Pharmaceuticals in this litigation. I'm here with</p> <p>13 Greenberg Traurig. My partner Nilda Isidro is here as</p> <p>14 well, and I'm going to be asking you a bunch of questions</p> <p>15 this morning, possibly into this afternoon as well about</p> <p>16 your report and the litigation and your opinions in the</p> <p>17 litigation.</p> <p>18 Have you ever had your deposition taken</p> <p>19 before?</p> <p>20 A. Yes.</p> <p>21 Q. How many times?</p> <p>22 A. Three or four times, maybe more. Six times.</p> <p>23 Q. Okay. So then you know how it goes. You're</p> <p>24 under oath, so you have sworn to tell the truth.</p>	<p style="text-align: right;">Page 12</p> <p>1 well.</p> <p>2 A. Okay.</p> <p>3 Q. In the prior depositions that you've taken or</p> <p>4 that you've been deposed, can you tell me when the first</p> <p>5 one was, approximately?</p> <p>6 A. Twenty years ago.</p> <p>7 Q. What kind of case was it?</p> <p>8 A. Malpractice.</p> <p>9 Q. Medical malpractice?</p> <p>10 A. Medical malpractice.</p> <p>11 Q. And were you a party in that case or were you</p> <p>12 a witness?</p> <p>13 A. A witness.</p> <p>14 Q. Were you an expert witness in that case?</p> <p>15 A. I believe I was an expert witness in that</p> <p>16 case.</p> <p>17 Q. Were you paid to testify?</p> <p>18 A. Yes.</p> <p>19 Q. And can you give me some of the details of</p> <p>20 that case?</p> <p>21 A. I can't remember exactly because it's been</p> <p>22 more than ten years since I've done any, but if it's the</p> <p>23 one I'm thinking of then, it was -- it was a woman with</p> <p>24 breast cancer, and I was asked to be an expert for the</p>
<p style="text-align: right;">Page 11</p> <p>1 The way this works obviously is I'm going to</p> <p>2 ask you questions. You're going to answer my questions.</p> <p>3 It will be recorded by both the videographer and the</p> <p>4 stenographer here, so there will be a booklet that has --</p> <p>5 there'll be a transcript that will have all of your</p> <p>6 testimony in it. Do you understand that?</p> <p>7 A. I do. Since this is video and I've not been</p> <p>8 videoed, when I nod my head, that works because in the</p> <p>9 past --</p> <p>10 Q. It doesn't. No, you still need to answer</p> <p>11 verbally so the stenographer can get it.</p> <p>12 A. Got it. Okay.</p> <p>13 Q. But thank you for asking.</p> <p>14 If I ask a question and you're not quite sure</p> <p>15 what I mean, please tell me.</p> <p>16 A. Okay.</p> <p>17 Q. Because if you answer my question, I'm going</p> <p>18 to assume that you understood it, and then it will go</p> <p>19 into the record. We don't want to have any</p> <p>20 misunderstandings. Okay?</p> <p>21 A. Okay.</p> <p>22 Q. Also, I do have a habit sometimes of speaking</p> <p>23 quickly, so I want to warn you in advance of that, so</p> <p>24 let's try not to talk over each other, and I will try as</p>	<p style="text-align: right;">Page 13</p> <p>1 plaintiff.</p> <p>2 Q. And what was the claim in that case?</p> <p>3 A. The claim was -- was that she was</p> <p>4 misdiagnosed. Late diagnosis caused her -- her disease</p> <p>5 to progress and ultimately caused her demise.</p> <p>6 Q. You say that was about 20 years ago you</p> <p>7 think?</p> <p>8 A. I believe it was about 20 years ago.</p> <p>9 Q. Where was that case?</p> <p>10 A. It was in -- it was on the west -- it was on</p> <p>11 the north -- in the northwestern United States.</p> <p>12 Q. Oregon, Washington, something like that?</p> <p>13 A. One of those places.</p> <p>14 Q. You don't remember though?</p> <p>15 A. I will later on I'm sure.</p> <p>16 Q. Okay. Well, if you remember, please let us</p> <p>17 know.</p> <p>18 A. Okay.</p> <p>19 Q. Do you remember the name of the attorney that</p> <p>20 retained you?</p> <p>21 A. I do not.</p> <p>22 Q. Do you remember the name of the firm?</p> <p>23 A. It was an independent person. He was not</p> <p>24 generally a malpractice attorney. That much I remember.</p>

<p style="text-align: right;">Page 14</p> <p>1 I don't remember his name.</p> <p>2 Q. How did he find you?</p> <p>3 A. Through a radiologist friend of mine who was</p> <p>4 asked -- who had done a lot of this and was asked to find</p> <p>5 a medical oncologist that could review the case and</p> <p>6 opine.</p> <p>7 Q. And when you say "review the case," did you</p> <p>8 testify in that case as well?</p> <p>9 A. Yes.</p> <p>10 Q. At deposition, as you said you did?</p> <p>11 A. I testified in court.</p> <p>12 Q. And at deposition, both?</p> <p>13 A. And in deposition.</p> <p>14 Q. And what was the result of that case?</p> <p>15 A. I believe that the case was dropped. I don't</p> <p>16 think it -- it went to court, but I don't think it -- it</p> <p>17 progressed after the time I was in the courtroom.</p> <p>18 Q. When you say it was dropped, do you know what</p> <p>19 you mean by that or is that just a layman's term?</p> <p>20 A. Honestly I --</p> <p>21 MS. GEMAN: I just want to caution you both.</p> <p>22 Please let him finish his question --</p> <p>23 THE WITNESS: Oh.</p> <p>24 MS. GEMAN: -- and likewise.</p>	<p style="text-align: right;">Page 16</p> <p>1 and a medical center I believe or a hospital.</p> <p>2 Q. Do you know what hospital that was or what</p> <p>3 medical center it was?</p> <p>4 A. I don't remember any of the details.</p> <p>5 Q. Okay. Do you remember anything else about</p> <p>6 that particular case?</p> <p>7 A. No, I really don't.</p> <p>8 Q. Okay. When was the next time you had your</p> <p>9 deposition taken?</p> <p>10 A. I really can't remember the times of these.</p> <p>11 I know I have had nothing within the last ten years.</p> <p>12 That's really what I can tell you.</p> <p>13 Q. Okay. I believe you testified that your</p> <p>14 deposition has been taken three or four times. So you</p> <p>15 told us about one.</p> <p>16 A. Right.</p> <p>17 Q. Can you tell us about another one?</p> <p>18 MS. GEMAN: Just objection to the extent it</p> <p>19 misstates testimony.</p> <p>20 MR. KERNER: I'm sorry. I didn't hear it.</p> <p>21 MS. GEMAN: Maybe I should take this off.</p> <p>22 Sorry.</p> <p>23 Objection to the extent it misstates</p> <p>24 testimony.</p>
<p style="text-align: right;">Page 15</p> <p>1 MR. KERNER: I warned you.</p> <p>2 MS. GEMAN: Right, but there was --</p> <p>3 MR. KERNER: Almost.</p> <p>4 MS. GEMAN: No, there was one cutoff of the</p> <p>5 answer. Thank you, both.</p> <p>6 THE WITNESS: Could you repeat the question?</p> <p>7 BY MR. KERNER:</p> <p>8 Q. Sure. You said the case was dropped. Do you</p> <p>9 know what you meant by that?</p> <p>10 A. So I can't remember if that case was -- was</p> <p>11 withdrawn or if it was that they found in favor of the</p> <p>12 defendant. I don't -- and it came to conclusion, but</p> <p>13 after my testimony I didn't have any more interaction. I</p> <p>14 think they had -- the attorney and the client had some</p> <p>15 issues, and I think they may have got other counsel. I</p> <p>16 can't remember all the details.</p> <p>17 Q. Okay. Do you remember the name of the case?</p> <p>18 A. No, I do not.</p> <p>19 Q. Do you remember the name of the defendant --</p> <p>20 A. I do not.</p> <p>21 Q. -- the name of the doctor?</p> <p>22 A. I do not.</p> <p>23 Q. Was it a doctor? Sorry.</p> <p>24 A. It was -- it was a doctor, a group of doctors</p>	<p style="text-align: right;">Page 17</p> <p>1</p> <p>2 BY THE WITNESS:</p> <p>3 A. I had a deposition taken on a patient that I</p> <p>4 was caring for. In fact, this was probably even before</p> <p>5 that case, so it may have been more like 25 years ago.</p> <p>6 And it was a young woman who had gastroesophageal cancer</p> <p>7 or stomach cancer. I can't remember exactly. She was my</p> <p>8 patient for a brief time. It was towards the end of</p> <p>9 her -- of her life, and I was asked -- I was deposed</p> <p>10 to -- as to her condition and to the -- and to the issues</p> <p>11 surrounding her diagnosis. I wasn't opining as to -- as</p> <p>12 to causation or -- or fault. I was just deposed as her</p> <p>13 treating doctor.</p> <p>14 BY MR. KERNER:</p> <p>15 Q. Were you a party in that case?</p> <p>16 A. No.</p> <p>17 Q. You weren't a defendant in that case?</p> <p>18 A. No, I was not.</p> <p>19 Q. So you were just a fact witness?</p> <p>20 A. I was a -- I was a treating physician at the</p> <p>21 time of her death.</p> <p>22 Q. Okay. Do you remember where that case was</p> <p>23 pending?</p> <p>24 A. It was in my office in Skokie.</p>

<p style="text-align: right;">Page 18</p> <p>1 Q. Do you remember the name of the attorney who</p> <p>2 took your deposition?</p> <p>3 A. I do not.</p> <p>4 Q. Do you remember the name of the doctor who</p> <p>5 was the -- was the doctor -- was there a doctor as the</p> <p>6 defendant in the case?</p> <p>7 A. There probably was, but I wasn't -- I wasn't</p> <p>8 really asked to look at any of that. It just was my own</p> <p>9 records and my own treatment of the patient.</p> <p>10 Q. Okay. And again just to be clear, you don't</p> <p>11 remember the name of either party or any of the parties</p> <p>12 in that case?</p> <p>13 A. I do not.</p> <p>14 Q. Any other depositions that you've taken or</p> <p>15 you've had rather?</p> <p>16 A. I've done other depositions. I was deposed</p> <p>17 as an expert reviewing a patient -- it wasn't a -- he</p> <p>18 became a patient but it was a -- a person who was</p> <p>19 claiming exposure to toxins in the workplace, and his</p> <p>20 attorney wanted me to review that and to opine as to</p> <p>21 whether any of the chemicals that he was exposed to could</p> <p>22 have been related to his ultimate development of cancer.</p> <p>23 Q. What kind of cancer did this person have?</p> <p>24 A. I believe it was a soft tissue sarcoma.</p>	<p style="text-align: right;">Page 20</p> <p>1 A. Just that there were some -- some</p> <p>2 benzene-type products that were -- there were some fairly</p> <p>3 toxic substances that are used commonly in -- in cleaning</p> <p>4 solutions in the workplace and at home, but I don't</p> <p>5 remember specifics.</p> <p>6 Q. And I'm sorry if I asked you this already.</p> <p>7 Do you remember the name of any of the parties in that</p> <p>8 case?</p> <p>9 A. I -- I do not.</p> <p>10 Q. What about any of the attorneys that you</p> <p>11 dealt with?</p> <p>12 A. I -- I don't offhand remember the names. If</p> <p>13 I need to look --</p> <p>14 Q. Why do you say it like that?</p> <p>15 A. Because I can't --</p> <p>16 MS. GEMAN: Objection.</p> <p>17 BY THE WITNESS:</p> <p>18 A. I can't remember the names. If I knew that I</p> <p>19 was going to be asked for depositions from before ten</p> <p>20 years, I would have reviewed whatever I could find in my</p> <p>21 old records to -- to get names and dates and places.</p> <p>22 BY MR. KERNER:</p> <p>23 Q. Okay. And so is it your testimony that you</p> <p>24 have some old records either at home or in your office</p>
<p style="text-align: right;">Page 19</p> <p>1 Q. So he was the plaintiff in that case?</p> <p>2 A. He was the -- he was the plaintiff, correct.</p> <p>3 Q. And his attorney asked you to review the</p> <p>4 medical records?</p> <p>5 A. To review the -- to review the medical</p> <p>6 records but also to review the -- the various agents that</p> <p>7 he was exposed to and see if I could find any -- any</p> <p>8 specific link or causation for his ultimate cancer.</p> <p>9 Q. And were you able to?</p> <p>10 A. I was not able to find anything specifically</p> <p>11 linked.</p> <p>12 Q. Do you recall what agents you looked at?</p> <p>13 A. I just recall that there were a lot of --</p> <p>14 of -- of cleaning agents. He was involved in -- in a</p> <p>15 factory that used a lot of solvents that were for -- for</p> <p>16 sterilization and cleaning, and I know I reviewed a lot</p> <p>17 of -- a lot of literature about those agents, and there</p> <p>18 was not any specific -- they were all -- they were all</p> <p>19 pretty much doing all the precautionary things that they</p> <p>20 needed to do in the work -- in the workforce.</p> <p>21 Q. Do you remember what any of the agents were?</p> <p>22 A. I really don't.</p> <p>23 Q. Do you remember any of the classifications of</p> <p>24 any of those agents?</p>	<p style="text-align: right;">Page 21</p> <p>1 that you would have reviewed?</p> <p>2 MS. GEMAN: Objection, misstates the</p> <p>3 testimony.</p> <p>4 BY THE WITNESS:</p> <p>5 A. It's -- could you repeat that, please.</p> <p>6 BY MR. KERNER:</p> <p>7 Q. Sure. Do I understand your testimony to be</p> <p>8 that you have old records that you didn't review from</p> <p>9 prior to ten years ago?</p> <p>10 A. What I'm saying is I could very well have</p> <p>11 something like that laying around since I tend not to</p> <p>12 throw things away, but I haven't looked in certain</p> <p>13 closets in the house for many years, so I would have to</p> <p>14 go looking through those if -- if I was being asked or</p> <p>15 knew I was going to be asked about them.</p> <p>16 Q. Okay. Any other occasions where your</p> <p>17 deposition was taken?</p> <p>18 A. I can't recall any -- any specifics of any</p> <p>19 other depositions, but I know I've been in my office</p> <p>20 deposed before.</p> <p>21 Q. And before this litigation -- you've been</p> <p>22 retained as an expert witness in this litigation;</p> <p>23 correct?</p> <p>24 A. Correct.</p>

<p style="text-align: right;">Page 22</p> <p>1 Q. For the Plaintiffs; correct?</p> <p>2 A. Correct.</p> <p>3 Q. Before this litigation how many times have</p> <p>4 you been retained as an expert witness?</p> <p>5 A. Again, it's been awhile. The last -- last 15</p> <p>6 years was doing nothing in this regard because I was</p> <p>7 taking care of my wife who suffered from breast cancer</p> <p>8 and then ultimately passed away from it, so I was kind of</p> <p>9 out of the picture, and this is the first I've done in a</p> <p>10 long time. But your question was how -- how many times</p> <p>11 was I an expert?</p> <p>12 Q. Correct.</p> <p>13 A. Aside from the case that I just mentioned to</p> <p>14 you, I've been an expert in malpractice cases. Mostly</p> <p>15 record review rather than -- rather than deposition.</p> <p>16 Only a couple times did it actually go to deposition.</p> <p>17 Q. Can you ballpark or estimate for me how many</p> <p>18 times you've been retained as an expert witness either to</p> <p>19 review documents or testify, a number?</p> <p>20 A. In my lifetime?</p> <p>21 Q. Yeah.</p> <p>22 A. Seven or eight times.</p> <p>23 Q. And out of that seven or eight total times,</p> <p>24 how many times do you think it went to deposition?</p>	<p style="text-align: right;">Page 24</p> <p>1 retained as an expert witness in a case that is not a</p> <p>2 medical malpractice case?</p> <p>3 A. Yes.</p> <p>4 Q. And so now you've given us all of the</p> <p>5 depositions that you can remember as you sit here;</p> <p>6 correct?</p> <p>7 A. Correct.</p> <p>8 Q. What's your current professional address?</p> <p>9 A. 9 -- 9631 Gross Point Road, Skokie, Illinois,</p> <p>10 60076.</p> <p>11 Q. Is that an office or a hospital?</p> <p>12 A. It's an office building.</p> <p>13 Q. And you have a practice that's just you?</p> <p>14 What is there?</p> <p>15 A. It's a private practice that includes myself,</p> <p>16 one employed physician and then nurses and physician</p> <p>17 assistant and staff.</p> <p>18 Q. And is it an oncology practice?</p> <p>19 A. Yes, hematology and oncology.</p> <p>20 Q. Tell me what hematology is.</p> <p>21 A. Hematology is the study of -- of</p> <p>22 blood-related disorders.</p> <p>23 Q. So is the practice primarily involved with</p> <p>24 blood cancers?</p>
<p style="text-align: right;">Page 23</p> <p>1 A. Three.</p> <p>2 Q. Okay. In those seven or eight total times</p> <p>3 where you've been retained as an expert witness, how many</p> <p>4 times were you retained for the defendant -- by the</p> <p>5 defendant?</p> <p>6 A. It was about 50/50 percent.</p> <p>7 Q. And in the times that you were retained by</p> <p>8 the defendant, were those defendants physicians?</p> <p>9 A. Yes.</p> <p>10 Q. Were there any occasions where the defendant</p> <p>11 was not a physician, where you were retained by a</p> <p>12 defendant who was not a physician?</p> <p>13 A. I don't believe so.</p> <p>14 Q. And so those would have been malpractice</p> <p>15 cases?</p> <p>16 A. Correct.</p> <p>17 Q. And in the times that you were retained by</p> <p>18 the plaintiff or plaintiffs, putting aside this</p> <p>19 litigation, how many of those were medical malpractice</p> <p>20 cases?</p> <p>21 A. All.</p> <p>22 Q. All?</p> <p>23 A. Um-hum. Yes.</p> <p>24 Q. So is this the first time that you have been</p>	<p style="text-align: right;">Page 25</p> <p>1 A. No.</p> <p>2 Q. What type of cancers does this practice deal</p> <p>3 with? Strike that.</p> <p>4 Hematology and oncology. So does the</p> <p>5 practice deal with more than just cancer?</p> <p>6 A. Yes.</p> <p>7 Q. Does it deal with blood disorders and</p> <p>8 cancers?</p> <p>9 A. Correct.</p> <p>10 Q. What kind of blood disorders does it deal</p> <p>11 with?</p> <p>12 A. Well, aside from the malignant blood</p> <p>13 disorders such as lymphomas, leukemias there are --</p> <p>14 Q. And those are cancers?</p> <p>15 A. Those are cancers. So you want the</p> <p>16 non-cancers?</p> <p>17 Q. Correct.</p> <p>18 A. So that would be -- that would be anemia,</p> <p>19 problems with other blood issues such as low platelet</p> <p>20 count, thrombocytopenia, bone marrow disorders such as</p> <p>21 mild dysplastic syndrome, mild proliferative neoplasms,</p> <p>22 multiple myeloma or plasma self dysplasias which kind of</p> <p>23 is the broad term for -- for that class of illnesses.</p> <p>24 Many things called monoclonal gammopathy of uncertain</p>

<p style="text-align: right;">Page 26</p> <p>1 significance or MGUS which is pre-cursor to multiple 2 myeloma, problems with just low blood counts in general, 3 sickle cell disease, hemophilia. Those conditions are 4 taken care of by my associate. 5 Q. You anticipated my question. So those blood 6 disorders are dealt with by your associate? 7 A. Correct. 8 Q. And what is his or her name? 9 A. Dr. Marlon Kleinman. Marlon like Brando. 10 Kleinman like Kleinman. 11 Q. And are you the only oncologist in the 12 practice? 13 A. He's also an oncologist. 14 Q. Okay. And in that practice, do you deal 15 exclusively with cancers? 16 A. No. I also do some hematology. We cover for 17 each other. I do have some patients with those 18 conditions I mentioned. 19 Q. Okay. What kind of cancers do you deal with 20 in that practice? 21 A. Pretty much any cancer that there is except 22 mostly I do not take care of acute leukemia. My partner 23 sometimes will. My associate sometimes will, but mostly 24 I take care of everything else. The majority of what I</p>	<p style="text-align: right;">Page 28</p> <p>1 A. Most of the time, yes. 2 Q. By the way, a couple of preliminary questions 3 I should have asked at the beginning. 4 You're not taking any medication that affects 5 your memory today? 6 A. I don't think so. No, I'm not taking any. 7 I'm sorry. 8 Q. And you're capable of testifying fully and 9 truthfully today? 10 A. I better be, yes. 11 Q. That's a yes? 12 A. I've already started. Yes. Yes. 13 Q. I am going to hand you what the court 14 reporter first -- we'll have her mark as Exhibit 1, the 15 Notice of Videotaped Deposition today. 16 (Exhibit No. 1 marked as 17 requested.) 18 MR. KERNER: Rachel, are you looking at the 19 same thing? 20 MS. GEMAN: Yes. 21 BY MR. KERNER: 22 Q. Dr. Kaplan, have you ever seen what's been 23 marked as Exhibit 1 prior to right now? 24 A. Yes.</p>
<p style="text-align: right;">Page 27</p> <p>1 do though is solid tumors which would include 2 gastrointestinal malignancies, lung cancer, breast 3 cancer, lymphomas, other -- other GI -- oh, I mentioned 4 gastrointestinal cancers. That could be -- that could be 5 anywhere from the esophagus to the stomach to the small 6 bowel to the large bowel, pancreas, gallbladder, biliary 7 tree cancers, liver cancers. 8 Q. Why don't you handle acute leukemia cases? 9 A. Most of the time I believe that that disease 10 requires the facilities of a tertiary care center, and 11 while we may see patients that are also being treated in 12 one of those centers, the majority of the treatment is 13 administered and followed at those centers. 14 Q. Are there any other cancers you'd put into 15 that same category? 16 A. No. 17 Q. What's so unique about acute leukemia that 18 requires that? 19 A. Acute leukemia requires oftentimes inpatient 20 treatments with close monitoring. It could -- it could 21 require bone marrow transplantation and -- and other 22 procedures that we're just not equipped to handle in 23 an -- an in outpatient clinic, outpatient office. 24 Q. So you refer them to another facility?</p>	<p style="text-align: right;">Page 29</p> <p>1 Q. When was the first time you saw it? 2 A. I believe it was about three or four weeks 3 ago. 4 Q. How did you come to see it? 5 A. It was given to me by the attorneys. 6 Q. Which attorney? 7 A. Rachel or one of her colleagues. 8 Q. You don't remember? 9 A. I don't -- I don't remember, no. 10 Q. And you see that it calls for your deposition 11 right here today. So you're here pursuant to this Notice 12 of Deposition; correct? 13 A. Correct. 14 Q. There's also a request for some documents 15 here. Did you review that before today? 16 A. Yeah. 17 Q. On Monday we received some documents. Were 18 the documents that you provided in response to these 19 requests? 20 A. Yes. 21 Q. Any documents in these requests that you 22 didn't provide? 23 A. Not that I know of, no. 24 Q. So everything in these requests you provided</p>

<p style="text-align: right;">Page 30</p> <p>1 on Monday to us; correct?</p> <p>2 MS. GEMAN: Objection to the extent it calls</p> <p>3 for a legal conclusion subject to the responses and</p> <p>4 objections.</p> <p>5 MR. KERNER: Okay. Let me ask it a different</p> <p>6 way.</p> <p>7 BY MR. KERNER:</p> <p>8 Q. Is there anything in this set of requests,</p> <p>9 these 13 requests that you have not provided to us?</p> <p>10 A. I -- I do not believe so.</p> <p>11 Q. So I asked that as a double negative there.</p> <p>12 Have you provided everything that was requested in these</p> <p>13 13 requests --</p> <p>14 MS. GEMAN: Same objection.</p> <p>15 BY MR. KERNER:</p> <p>16 Q. -- that was in your -- that's in your</p> <p>17 possession?</p> <p>18 A. Yes.</p> <p>19 Q. And so request number 6 is for your complete</p> <p>20 and entire file for the case. You provided that?</p> <p>21 A. Yes.</p> <p>22 Q. So there's nothing that you have in</p> <p>23 connection with this case that you haven't provided; is</p> <p>24 that accurate?</p>	<p style="text-align: right;">Page 32</p> <p>1 THE WITNESS: Can I take a break for one</p> <p>2 second --</p> <p>3 MR. KERNER: Yeah, of course.</p> <p>4 THE WITNESS: -- just to ask a question?</p> <p>5 MR. KERNER: Hang on. Hang on. Do you want</p> <p>6 to go off the record? Yeah.</p> <p>7 THE VIDEOGRAPHER: The time is 9:41 a.m. This</p> <p>8 is the end of media two. We're off the record.</p> <p>9 (Discussion had off the</p> <p>10 record.)</p> <p>11 The time is 9:43 a.m. This is the</p> <p>12 beginning of media three. We're back on the record.</p> <p>13 BY MR. KERNER:</p> <p>14 Q. We all set?</p> <p>15 A. Yes.</p> <p>16 Q. Okay. Dr. Kaplan, how did you first become</p> <p>17 aware of this litigation?</p> <p>18 A. I was approached by or I was -- I was</p> <p>19 contacted by Expert Institute which is a company that has</p> <p>20 my -- my credentials, my information and they asked me if</p> <p>21 I'd be interested in discussing and reviewing this case</p> <p>22 and introduced me to the -- to the legal team that was</p> <p>23 involved in it.</p> <p>24 Q. Who did they introduce you to?</p>
<p style="text-align: right;">Page 31</p> <p>1 MS. GEMAN: Same objection.</p> <p>2 BY THE WITNESS:</p> <p>3 A. There -- there were preliminary drafts which</p> <p>4 I was told I did not need to -- to provide.</p> <p>5 MS. GEMAN: And I'm just going to caution the</p> <p>6 witness not to disclose communications with counsel.</p> <p>7 MR. KERNER: Right.</p> <p>8 BY THE WITNESS:</p> <p>9 A. And communication with counsel.</p> <p>10 BY MR. KERNER:</p> <p>11 Q. I don't want to know about your</p> <p>12 communications with your counsel. Although I believe</p> <p>13 counsel here is Plaintiffs' counsel, so you're actually</p> <p>14 not -- there's not an attorney/client relationship, but</p> <p>15 we don't need to get into that now.</p> <p>16 And I'm not looking for your drafts.</p> <p>17 A. I'm sorry?</p> <p>18 Q. I'm not looking for your drafts today.</p> <p>19 A. Okay.</p> <p>20 Q. Is there anything else that you didn't</p> <p>21 provide that was requested --</p> <p>22 A. No.</p> <p>23 Q. -- in these 13 requests?</p> <p>24 A. No, there isn't.</p>	<p style="text-align: right;">Page 33</p> <p>1 A. To -- to the law firm that -- that I'm --</p> <p>2 that I'm with right now.</p> <p>3 Q. Rachel's law firm?</p> <p>4 A. Rachel's law firm.</p> <p>5 Q. Lieff Cabraser, does that sound familiar?</p> <p>6 A. Yeah, that's one of the law firms.</p> <p>7 Q. What were the other ones?</p> <p>8 A. I don't have the names in front of me.</p> <p>9 Q. What did they tell you that they wanted you</p> <p>10 to do?</p> <p>11 A. They asked if I could review or -- or develop</p> <p>12 a monitoring program for patients that had been shown to</p> <p>13 be exposed to known carcinogens.</p> <p>14 Q. How do you define known carcinogens?</p> <p>15 A. Products that have been identified to</p> <p>16 increase risk of developing malignancies when someone's</p> <p>17 been exposed to them in certain levels.</p> <p>18 Q. And you said the Expert Institute put you in</p> <p>19 contact with Lieff Cabraser?</p> <p>20 A. Correct.</p> <p>21 Q. How did they have your contact information?</p> <p>22 A. I had responded to e-mail requests awhile ago</p> <p>23 for somebody who would be interested -- for people who</p> <p>24 would be interested in being expert witness and sent them</p>

<p style="text-align: right;">Page 34</p> <p>1 my information, my curriculum vitae, so I was on their 2 file. I don't remember how long ago I did it, but this 3 was the first time I had been contacted by them. 4 Q. How long ago did Plaintiffs' lawyers contact 5 you? 6 A. I believe it was October of 2021, September 7 or October. 8 Q. Just a few months ago? 9 A. Correct. Actually, it may have been a little 10 before. It may have been August. 11 Q. And they asked you to develop a monitoring 12 program for patients exposed to known carcinogens. How 13 did you respond? 14 MS. GEMAN: Objection to the extent it 15 misstates the testimony. 16 BY MR. KERNER: 17 Q. If that's not what you said, please correct 18 it, but I think that's what you said. 19 A. Could you repeat the question? 20 Q. How did you respond to Plaintiffs' request to 21 retain you as an expert? 22 A. I agreed to review the information. 23 Q. What information did you agree to review? 24 A. The testimony of experts that discussed the</p>	<p style="text-align: right;">Page 36</p> <p>1 MR. KERNER: Let's mark this next exhibit. I 2 think this is 2; right? 3 (Exhibit No. 2 marked as 4 requested.) 5 BY MR. KERNER: 6 Q. Doctor, we've marked as Exhibit -- well, 7 we've just handed you Exhibit 2. Can you tell me what 8 that is? 9 A. This is a copy of my curriculum vitae. 10 Q. And can you tell me if that's your most 11 current CV? 12 A. I believe it is. 13 Q. And this was attached to your report? 14 A. Yes. 15 MR. KERNER: How do we want to handle exhibits 16 with the Zoom? I realize we didn't do that for the 17 Notice of Deposition. Do we want to get the CV up on the 18 Zoom for folks that are remote? 19 MS. ISIDRO: Yes. That's in progress. 20 MR. KERNER: Great. 21 BY MR. KERNER: 22 Q. So, Doctor, let's go backwards. Let's start 23 with your medical school. Where did you go and when did 24 you graduate?</p>
<p style="text-align: right;">Page 35</p> <p>1 risks associated with nitrosamine products from tainted 2 Valsartan. 3 Q. Which specific expert's testimony did you 4 review? 5 A. I have it in my -- 6 Q. In your report? 7 A. -- report. 8 Q. So the experts' testimony that you reviewed 9 are the experts that you've identified in your report? 10 A. Correct. 11 Q. Any others? 12 A. No. 13 Q. And in addition to reviewing their testimony, 14 did you review anything else? 15 A. At that time? 16 Q. Yes. 17 A. No. 18 Q. In preparing your report, did you review 19 anything else or just that testimony? 20 A. No. In preparing my report, I reviewed 21 various articles and resources. 22 Q. And are those articles and resources attached 23 to your report? 24 A. Yes, they are.</p>	<p style="text-align: right;">Page 37</p> <p>1 A. I went to Loyola University Medical Center in 2 Maywood, Illinois, and I graduated in 1982. 3 Q. Did you have a residency after that? 4 A. I had a residency -- internship and residency 5 at Northwestern University in Chicago. 6 Q. What did you do after the internship and the 7 residency? 8 A. I went on to a hematology/oncology fellowship 9 at Northwestern University in Chicago. 10 Q. And the residency was in internal medicine; 11 correct? 12 A. Correct. 13 Q. And the fellowship was you said at 14 Northwestern -- 15 A. Yes. 16 Q. -- in hematology and oncology? 17 That was according to your CV from 1983 to 18 1985? 19 A. The fellowship was 1985 to 1988. 20 Q. Ahh, okay. And so after the fellowship, when 21 it concluded in 1988, what did you do next? 22 A. I joined the faculty at Rush University in 23 Chicago. 24 Q. In what role?</p>

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<p>1 A. As a medical -- as a hematology/oncology</p> <p>2 attending physician.</p> <p>3 Q. Is that still your role there?</p> <p>4 A. No. I was -- I was full-time there for five</p> <p>5 years and then went into private practice after that but</p> <p>6 maintained my -- my teaching role at Rush University and</p> <p>7 am still an Assistant Professor of Medicine at Rush</p> <p>8 University.</p> <p>9 Q. And you've been an Assistant Professor of</p> <p>10 Medicine at Rush since 1988?</p> <p>11 A. Correct.</p> <p>12 Q. What do your responsibilities at Rush entail</p> <p>13 now?</p> <p>14 A. My responsibilities at Rush would entail</p> <p>15 allowing residents and students to rotate through our</p> <p>16 office to acquire clinical experience. There's been</p> <p>17 teaching roles. There's been clinical clerkships, but I</p> <p>18 have had no responsibilities on the campus for a number</p> <p>19 of years.</p> <p>20 Q. When you say "allow them to rotate," what do</p> <p>21 you mean by that?</p> <p>22 A. Providing them a rotation, a clinical</p> <p>23 rotation in our -- in our -- in our practice for the --</p> <p>24 for the residents or -- or fellows that wish to have a</p>	<p>1 Q. And the invited lectures and presentations --</p> <p>2 A. Concerning?</p> <p>3 Q. -- any of them concerning NDMA or NDEA?</p> <p>4 A. No.</p> <p>5 Q. Or Valsartan?</p> <p>6 A. No.</p> <p>7 Q. Or the Valsartan drugs?</p> <p>8 A. Correct.</p> <p>9 Q. Other than the report that the Plaintiffs'</p> <p>10 attorneys asked you to draft and develop in this</p> <p>11 litigation have you ever written or presented or spoke</p> <p>12 outside the litigation on NDMA, NDEA or any of the</p> <p>13 Valsartan drugs?</p> <p>14 A. No, I haven't.</p> <p>15 Q. Since the litigation began other than your</p> <p>16 report, have you written or presented or spoken on NDMA,</p> <p>17 NDEA or any of the Valsartan drugs?</p> <p>18 A. No, I haven't.</p> <p>19 Q. So it's limited to this report; correct?</p> <p>20 A. Yes.</p> <p>21 Q. When the Plaintiffs asked -- Plaintiffs'</p> <p>22 counsel -- excuse me. Okay. I misspoke earlier.</p> <p>23 When Plaintiffs' counsel asked you to develop</p> <p>24 a monitoring program, did they give you any more guidance</p>
Page 39	Page 41
<p>1 community oncology experience.</p> <p>2 Q. Do you supervise them?</p> <p>3 A. Yes.</p> <p>4 Q. Do you teach them?</p> <p>5 A. Yes.</p> <p>6 Q. What do you teach them?</p> <p>7 A. Teach them clinical -- clinical oncology.</p> <p>8 For -- for ten years -- until 1995 I was assigned as</p> <p>9 the -- the Chairman of Oncology at NorthShore</p> <p>10 University -- at -- sorry -- at Rush NorthShore in</p> <p>11 Skokie. That was part of my role at Rush. After I left</p> <p>12 full-time faculty at Rush I maintained that role until</p> <p>13 the hospital was sold to NorthShore University.</p> <p>14 Q. Okay. Now, in looking at your CV, there are</p> <p>15 a bunch of publications, and I see there's some patents</p> <p>16 as well and some abstracts and invited lectures and</p> <p>17 presentations. How many of these publications dealt with</p> <p>18 NDMA or NDEA?</p> <p>19 A. None.</p> <p>20 Q. How about Valsartan or any of the Valsartan</p> <p>21 drugs?</p> <p>22 A. None.</p> <p>23 Q. What about the abstracts?</p> <p>24 A. None.</p>	<p>1 or instruction as to how to do it?</p> <p>2 A. No.</p> <p>3 Q. What they were looking for?</p> <p>4 A. No.</p> <p>5 Q. They just said develop a program and --</p> <p>6 A. They -- they --</p> <p>7 MR. KERNER: Go ahead. I'm sorry.</p> <p>8 MS. GEMAN: I just want to caution you. You</p> <p>9 can speak to any facts or assumptions provided, but I</p> <p>10 don't -- I don't see Mr. Kerner is asking beyond that.</p> <p>11 MR. KERNER: I think I heard you.</p> <p>12 MS. GEMAN: Sorry.</p> <p>13 MR. KERNER: That's okay. I know.</p> <p>14 THE WITNESS: Could you repeat the question?</p> <p>15 MR. KERNER: I'm not sure that I could.</p> <p>16 BY MR. KERNER:</p> <p>17 Q. When Plaintiffs' counsel asked you to develop</p> <p>18 a monitoring program, did they give you any instruction</p> <p>19 or guidance as to what they wanted?</p> <p>20 MS. GEMAN: Objection, asked and answered.</p> <p>21 BY THE WITNESS:</p> <p>22 A. They advised me as to the -- the details of</p> <p>23 the case and asked if I felt that I could present a</p> <p>24 monitoring program for the group of patients that were</p>

<p style="text-align: right;">Page 42</p> <p>1 identified as being at high risk for developing a group 2 of cancers. 3 BY MR. KERNER: 4 Q. And when you said they gave you the details 5 of the case, what did they tell you were the details? 6 A. The details were that it had been established 7 by their expert reviewers and by the history of the 8 litigation that the Valsartan tainted materials when 9 exposed in certain amounts to patients was considered a 10 risk for the patients ultimately developing malignancies, 11 that these were carcinogens and then the levels that they 12 were exposed to, that they were at risk. And part of 13 this kind of evaluation or legal review does allow for 14 monitoring, medical monitoring in situation, and my 15 experience with patient care and patient -- patient -- 16 review patient care would allow me to develop an 17 appropriate monitoring program in that situation. 18 Q. Okay. You said -- and I don't want to 19 misstate your testimony. I'm trying to remember what you 20 just said -- that their expert reviewers established that 21 Valsartan was considered an increased risk. Did you do 22 any independent analysis as to Valsartan or NDMA other 23 than what their other experts had established? 24 A. So my understanding, it wasn't Valsartan that</p>	<p style="text-align: right;">Page 44</p> <p>1 address. One of the attorneys -- one of the attorneys 2 for the Plaintiff. 3 Q. Somebody told you to address it to 4 Mr. Slater? 5 A. Correct. 6 Q. Do you remember who told you that? 7 A. No. 8 Q. Okay. You said a moment ago that -- I think 9 you said a moment ago that you were asked to develop a 10 medical monitoring program, and then I think you said the 11 legal review allows for medical monitoring in this case. 12 That's what you said; correct? 13 A. I think that's what my terminology was, yes. 14 Q. Prior to this case have you ever created a 15 medical monitoring program? 16 A. I've not developed a public medical 17 monitoring program but I've been involved in my own 18 patient care of -- of developing monitoring programs. 19 Q. What do those monitoring programs consist of? 20 And what do you mean by monitoring programs for your 21 patients? 22 A. So to get into detail, my experience in my 23 practice includes patients that have high risk of 24 developing cancer usually because of genetic</p>
<p style="text-align: right;">Page 43</p> <p>1 was putting the patients at risk. It was the Valsartan 2 that was manufactured in a way that had been tainted with 3 these dangerous substances. I did not do independent 4 review. That's not what I was asked to do. I was asked 5 to just develop a monitoring program. 6 Q. Okay. And -- and to your point, you don't 7 have any criticism of the drug Valsartan; correct? 8 A. Correct. 9 Q. And you're relying on the Plaintiffs' other 10 experts for their analysis of any carcinogenic effect of 11 the, as I think you put it, the tainted Valsartan; 12 correct? 13 A. Correct. 14 Q. Okay. Let's get to what we're going to mark 15 as Exhibit 3. 16 (Exhibit No. 3 marked as 17 requested.) 18 The Zoom folks be aware of that as well. 19 Okay. Doctor, can you tell me what Exhibit 3 20 is? 21 A. This was the report that I provided to the -- 22 to -- to Mr. Slater and the other attorneys. 23 Q. Who's Mr. Slater? 24 A. Mr. Slater is the one I was told to -- to</p>	<p style="text-align: right;">Page 45</p> <p>1 abnormalities such as BRCA gene or Lynch syndrome. I 2 follow patients and families of patients that haven't 3 developed cancer that -- but do carry these genetic 4 abnormalities and monitor them for malignancies. 5 Q. How do you do that? 6 A. Various ways depending on the situation. 7 Q. Can you explain that to me? 8 A. Certainly. In -- for example, in Lynch 9 syndrome which is genetic abnormality that predisposes to 10 gastrointestinal malignancies, I will follow the patients 11 twice a year. The ones that do not have cancer, have not 12 developed cancer we'll follow them twice a year with 13 clinical exam, routine exams that include physical exam, 14 history and basic blood analysis. I will assure that 15 they're getting annual colonoscopies because of the high 16 risk of developing polyposis and ultimately 17 gastrointest -- colonic carcinoma. I will also follow 18 them for development of uterine cancer by referring them 19 to gynecologist by ordering radiographic studies such as 20 ultrasounds, occasionally CAT scans. 21 Q. Let me interrupt you for one second, sir. 22 For Lynch syndrome, one of the things you just said I 23 think is that you -- you have them have an annual 24 colonoscopy --</p>

<p style="text-align: right;">Page 46</p> <p>1 A. Correct.</p> <p>2 Q. -- correct?</p> <p>3 Do you have all of your patients who are --</p> <p>4 is it -- are they -- do they have Lynch syndrome or are</p> <p>5 they susceptible to Lynch syndrome?</p> <p>6 A. No. These are patients --</p> <p>7 MS. GEMAN: I just want to --</p> <p>8 BY THE WITNESS:</p> <p>9 A. -- with --</p> <p>10 MS. GEMAN: I just want to object. The</p> <p>11 witness was not done answering the previous question, so</p> <p>12 I just want to make sure the record's clear that that</p> <p>13 wasn't an answer -- a complete answer.</p> <p>14 MR. KERNER: Sure, and we'll come back to that</p> <p>15 in a second. I appreciate that.</p> <p>16 MS. GEMAN: Yeah.</p> <p>17 BY MR. KERNER:</p> <p>18 Q. Lynch syndrome.</p> <p>19 A. Thank you. Patients that have identified</p> <p>20 Lynch syndrome, it's recommended that they get annual</p> <p>21 colonoscopies.</p> <p>22 Q. Are there patients who perhaps for other</p> <p>23 reasons, whether it's other history or comorbidities or</p> <p>24 something, might not be -- might not be appropriate to</p>	<p style="text-align: right;">Page 48</p> <p>1 Q. So you don't know if it's a national</p> <p>2 statistic or a worldwide statistic? It's just a Kaplan</p> <p>3 statistic of less than .1 percent of perforated colons?</p> <p>4 A. As I said, I was guessing it was either 1</p> <p>5 percent or maybe even .1 percent. I was not opining as</p> <p>6 to the exact statistic. I know that there's literature</p> <p>7 that could answer that question.</p> <p>8 Q. So to be fair, as you sit here right now, you</p> <p>9 don't really know how many -- what the percentage is of</p> <p>10 colonoscopy patients who have perforated colons during</p> <p>11 the procedure?</p> <p>12 A. I know it's very rare.</p> <p>13 Q. But you don't know what you mean by "very</p> <p>14 rare"?</p> <p>15 MS. GEMAN: Objection.</p> <p>16 BY MR. KERNER:</p> <p>17 Q. What do you mean by "very rare?"</p> <p>18 A. I've taken care of over 1,000 patients that</p> <p>19 have had colonoscopies, probably more like 3,000 patients</p> <p>20 in my career that have had colonoscopies and I've seen 2</p> <p>21 perforations.</p> <p>22 Q. But, again, as a good doctor who cares about</p> <p>23 his patients, you consider that as to whether a patient</p> <p>24 should have an annual colonoscopy; correct?</p>
<p style="text-align: right;">Page 47</p> <p>1 have an annual colonoscopy?</p> <p>2 A. Yes.</p> <p>3 Q. Can you give me an example or two of a type</p> <p>4 of patient where you wouldn't -- with Lynch syndrome</p> <p>5 where you wouldn't provide an annual colonoscopy for?</p> <p>6 A. An elderly patient with severe cardiovascular</p> <p>7 disease, somebody that had a colonoscopy and had a</p> <p>8 complication such as a perforation, someone that just</p> <p>9 refuses.</p> <p>10 Q. How common are perforations during</p> <p>11 colonoscopies?</p> <p>12 A. Very uncommon.</p> <p>13 Q. I'm sorry?</p> <p>14 A. Very uncommon. I believe less than 1</p> <p>15 percent. I believe less than .1 percent, but I don't</p> <p>16 know exactly.</p> <p>17 Q. Less than .1 percent?</p> <p>18 A. I believe so, but I don't know exactly.</p> <p>19 Q. You don't happen to have any data or support</p> <p>20 that you can cite to me for that figure, do you?</p> <p>21 A. No, I don't.</p> <p>22 Q. Do you know where that figure comes from?</p> <p>23 A. Just from my own experience in -- in</p> <p>24 practice.</p>	<p style="text-align: right;">Page 49</p> <p>1 A. Could you repeat that? I just got stopped at</p> <p>2 the "good doctor" because I'm glad you said that.</p> <p>3 Q. Yeah. Strike that.</p> <p>4 As a doctor who's concerned about his</p> <p>5 patients, I think you testified a few minutes ago that</p> <p>6 one of the reasons why you may not recommend an annual</p> <p>7 colonoscopy is if it's an elderly patient, the risk</p> <p>8 of -- the risk of a perforated colon and some other</p> <p>9 possible reasons?</p> <p>10 A. What I said was if someone had had a</p> <p>11 perforation in their colon I would not recommend going</p> <p>12 back necessarily with a colonoscopy.</p> <p>13 Q. Any other reasons why you might not recommend</p> <p>14 the annual colonoscopy for a Lynch syndrome patient?</p> <p>15 A. Aside from comorbidities, risk of problems</p> <p>16 related to anesthesia, I can't think of any other reason</p> <p>17 I would not recommend an annual colonoscopy.</p> <p>18 Q. So there are some risks that are -- that come</p> <p>19 along with a colonoscopy; correct?</p> <p>20 A. Correct.</p> <p>21 Q. And so what you do with your patients with</p> <p>22 Lynch syndrome is you weigh the risks versus the</p> <p>23 benefits?</p> <p>24 A. Correct.</p>

<p style="text-align: right;">Page 50</p> <p>1 Q. And in your medical judgment, as a treating 2 physician of those patients, you make the recommendation 3 one way or the other; correct? 4 A. Correct. 5 Q. One of the things I think you said is that -- 6 I'll let you finish taking your notes. 7 A. I was saying you said I was a good doctor. 8 Sorry. 9 Q. One of the things I think you said with 10 respect to Lynch syndrome is that it is recommended that 11 they have annual colonoscopies? 12 A. Correct. 13 Q. By whom? 14 A. By I believe a number of agencies. The NCCN 15 has it in their guidelines. 16 Q. What's the NCCN? 17 A. The NCCN is the National -- I knew you were 18 going to ask me this. I can't remember what it stands 19 for. It's a -- it's a -- it's an organization that's -- 20 that reviews every malignancy class and has experts from 21 around the country and even around the world will meet 22 regularly and create algorithms for how many conditions 23 are treated but also for screening and for -- and for 24 monitoring.</p>	<p style="text-align: right;">Page 52</p> <p>1 A. Well, of course, the patient. 2 Q. What do you look at with respect to the 3 patient? 4 A. This is when deciding on treatment for the 5 patient? 6 Q. Yes. 7 A. The -- the details of the patient's specific 8 situation, the disease itself, of course, the performance 9 status of the patient which is a measure of how 10 functional and how sick they are, the comorbidities, 11 patient's desires themselves. 12 Q. Family history? 13 A. In deciding on treatment, usually not. 14 Q. Would you take family history into account in 15 determining whether a certain procedure is appropriate 16 and may be more likely to be appropriate because of 17 family history? 18 A. Could you explain that question? 19 Q. Sure. For colonoscopy would you be more 20 likely to think a colonoscopy is appropriate annually 21 because they have Lynch syndrome? 22 A. Yes. I already mentioned that Lynch -- 23 Q. Right. 24 A. -- syndrome, but Lynch syndrome, although</p>
<p style="text-align: right;">Page 51</p> <p>1 Q. Is it the National Comprehensive Cancer 2 Network? 3 A. That's it. Thank you. 4 Q. And they develop screening protocols, is that 5 what -- 6 A. They have recommendations in their algorithm 7 for what should be done with patients. 8 Q. They're pretty well-regarded; right? 9 A. Yes. 10 Q. Do you generally follow their guidelines? 11 A. Generally. 12 Q. Are there specific guidelines that you don't 13 follow? 14 A. On an individual basis I will review -- and 15 this is usually for treating patients. I will review 16 their recommendations, and they usually have more than 17 one suggested direction, but we use them to -- to help 18 decide on appropriate treatments for patients. 19 Q. What else do you use to decide on appropriate 20 treatments for patients? 21 A. My own experience, the literature, any 22 investigational trials that we're involved in or that 23 we've reviewed. 24 Q. What about the patient him or herself?</p>	<p style="text-align: right;">Page 53</p> <p>1 it's linked to family history, it's specific to that 2 patient because they've been diagnosed with carrying the 3 gene. 4 Q. Fair. What about a patient who has a first 5 degree relative who has had colon cancer? 6 A. That would -- 7 MS. GEMAN: Objection, vague. 8 BY THE WITNESS: 9 A. That would factor into my -- my assessment of 10 the patient's own risk and the need for that patient to 11 undergo genetic testing but wouldn't necessarily -- 12 wouldn't necessarily at all factor into my decision about 13 putting them through colonoscopy or any other test. It's 14 part of the general evaluation of the patient. 15 BY MR. KERNER: 16 Q. Okay. So in terms of treatment which is what 17 you're talking about? 18 A. Correct. 19 Q. You mentioned comorbidities. You mentioned 20 the patient's desires. You mentioned the performance 21 status of the patient. What do you mean by that? 22 A. So in part of the evaluation of a patient, 23 and especially oncology patients that are going through 24 treatments or are anticipating going through treatments,</p>

<p style="text-align: right;">Page 54</p> <p>1 one of the ways to quantitate how the patient is doing is 2 using a -- a table, a gauge based on a number of factors 3 to determine how fit they are. There's two accepted 4 methods. One is called the ECOG, Eastern Cooperative 5 Oncology Group Performance Status, and the other is the 6 Karnofsky Performance Status. We usually use the ECOG 7 criteria. It's pretty straightforward. It's from zero 8 to four. Zero is somebody that's totally asymptomatic 9 and performing their normal day-to-day activities. One 10 is somebody that's functional and doing everything but 11 probably at better than 50 percent of their normal 12 activities. Two is -- two and three and four are then 13 progressively worse, with four being near death. 14 Q. And so that will help guide you with the 15 treatment that you're going to provide for the patient; 16 correct? 17 A. Correct. 18 Q. One of the things? 19 A. Correct. 20 Q. And is that something that NCCN also -- it's 21 also part of their guidelines? 22 A. I'm not exactly sure how -- how they would 23 use it in their guidelines. I believe they do. I think 24 there's many studies suggesting that someone that is a</p>	<p style="text-align: right;">Page 56</p> <p>1 cancer recurrence." We've talked a little bit about that 2 already; correct? 3 A. Yes. 4 Q. Anything about the screening programs that 5 you said you designed for your patients that you haven't 6 told us yet? 7 MS. GEMAN: Objection. 8 BY THE WITNESS: 9 A. We didn't talk about patients that have been 10 treated for cancer, and so they're in a unique group 11 that's going to be monitored a little differently than a 12 healthy person that walks in that needs to be evaluated 13 with cancer. 14 BY MR. KERNER: 15 Q. And that's where you're talking about cancer 16 recurrence; correct? 17 A. Correct. 18 Q. So tell me what the difference is in your 19 view with a patient who you're screening for a risk of 20 cancer versus a cancer recurrence. Because I would 21 assume, I shouldn't, but that somebody you're treating 22 for cancer recurrence you might be a little bit more 23 aggressive in terms of your -- in terms of your 24 screening?</p>
<p style="text-align: right;">Page 55</p> <p>1 performance status of three or worse is not likely to 2 benefit from some of the aggressive treatments we might 3 otherwise use that's been established. Although a lot of 4 that's changing because of new therapies that have come 5 out that are even appropriate for very ill patients. 6 Q. Okay. Let's take a look at your report. 7 A. Okay. 8 Q. And we've marked that as Exhibit 3. 9 You want to get that back up for the Zoom? 10 Okay. Did you draft this report? 11 A. Yes. 12 Q. Did Plaintiffs' counsel provide any input in 13 the report? 14 A. Only typographically. 15 Q. And you mean literally typos -- 16 A. Correct. 17 Q. -- if there were errors? That's it? 18 A. Yeah. 19 Q. Nothing else? 20 A. I don't believe so, no. 21 Q. Okay. Let's go -- in the first paragraph, 22 "Expert Background Qualifications," you mention that you 23 "designed screening programs for the patient I treat and 24 frequently monitor patients at high risk for cancer or</p>	<p style="text-align: right;">Page 57</p> <p>1 A. I'm not sure what aggressive -- 2 Q. Strike that. 3 A. -- means. From where? 4 Q. Tell me -- tell me how your screening is 5 different for patients at high risk for cancer versus 6 patients with cancer recurrence. 7 A. All of the patients will receive general 8 evaluation. By that I mean history, a physical exam, 9 basic laboratory studies. Patients with specific 10 conditions will have blood tests that are designed 11 specifically for that cancer. For example, ovarian 12 cancer with a tumor marker called CA125 or pancreatic 13 cancer with a tumor marker called CA929, I won't do that 14 on a patient who didn't have the history of pancreatic 15 cancer necessarily. 16 Q. Why not? 17 A. Because that test is designed specifically 18 to -- to detect pancreatic cancer recurrence. 19 Q. Okay. 20 A. The other thing might be, as you alluded to, 21 more aggressive procedures, so that might include doing 22 CAT scans more frequently. Somebody that's had lung 23 cancer that's been treated that had surgery but is high 24 risk for recurrence will get CAT scans frequently.</p>

<p style="text-align: right;">Page 58</p> <p>1 Q. What do you mean "frequently"?</p> <p>2 A. I mean depending on where they are from their</p> <p>3 treatment and what their situation is and what their</p> <p>4 symptoms are. It could be -- it could be every three</p> <p>5 months, every four months, every six months, every year.</p> <p>6 It's not set in stone. It depends on the patient.</p> <p>7 Q. And that would be true for patients who you</p> <p>8 believe are at high risk for cancer. It depends on the</p> <p>9 patient in terms of what the screening will be; correct?</p> <p>10 A. Well, not necessarily. Patients that are at</p> <p>11 high risk for cancer that have no other symptoms or</p> <p>12 problems I will have a specific general monitoring scheme</p> <p>13 in mind which is exactly what this is all about. While</p> <p>14 as patients that have had a specific problem or have a</p> <p>15 symptom will necessitate getting additional testing done.</p> <p>16 Q. Okay. So there are -- at least in this first</p> <p>17 section of your report, there are screening programs for</p> <p>18 patients at high risk for cancer and for cancer</p> <p>19 recurrence. Do you make any other distinctions between</p> <p>20 asymptomatic or symptomatic patients or patients with</p> <p>21 specific exposures?</p> <p>22 MS. GEMAN: Objection.</p> <p>23 BY THE WITNESS:</p> <p>24 A. I'm not sure I understand the question.</p>	<p style="text-align: right;">Page 60</p> <p>1 or could be many different types, there's going to be</p> <p>2 general screening protocols that I'll provide. An</p> <p>3 example would be someone with tobacco exposure's not just</p> <p>4 at risk for one cancer, so it would be a number of -- of</p> <p>5 procedures that are done to monitor them.</p> <p>6 MR. KERNER: Okay. Let's take a five-minute</p> <p>7 break if we can. We've been at it a little over an hour.</p> <p>8 THE VIDEOGRAPHER: The time is now 10:21 a.m.</p> <p>9 This is the end of media three. We're off the record.</p> <p>10 (WHEREUPON, a break was</p> <p>11 taken.)</p> <p>12 The time is now 10:39 a.m. This is the</p> <p>13 beginning of media four. We're back on the record.</p> <p>14 BY MR. KERNER:</p> <p>15 Q. Okay, Doctor. A few more questions</p> <p>16 obviously.</p> <p>17 We're talking about paragraph 1 in your</p> <p>18 report, and I want to talk about your practice. You</p> <p>19 mentioned that you designed screening programs for</p> <p>20 certain patients. I think you testified that you have</p> <p>21 designed screening programs for patients with genetic</p> <p>22 predisposition such as BRCA or Lynch syndrome; is that</p> <p>23 correct?</p> <p>24 A. Correct.</p>
<p style="text-align: right;">Page 59</p> <p>1</p> <p>2 BY MR. KERNER:</p> <p>3 Q. Okay. In your practice, when you're</p> <p>4 screening your patients, do you make any distinctions if</p> <p>5 a patient is symptomatic or asymptomatic in terms of the</p> <p>6 screening?</p> <p>7 A. The basic screening there will be no</p> <p>8 distinction. If someone's symptomatic, that goes on from</p> <p>9 screening to evaluation. So somebody, for example, that</p> <p>10 has a cough is going to have something done more to</p> <p>11 evaluate that than someone that comes in without any</p> <p>12 symptoms, but there's a basic screening that would be</p> <p>13 provided to anybody that I identified as being at risk.</p> <p>14 Q. At risk for what?</p> <p>15 A. Developing cancer.</p> <p>16 Q. Which type of cancer?</p> <p>17 A. All -- all -- I mean it depends on what I'm</p> <p>18 seeing the patient for.</p> <p>19 Q. Sure. So are there different screening</p> <p>20 protocols for different risks -- different cancer risks?</p> <p>21 A. There are screening programs for -- there's</p> <p>22 individual decisions that are made based on a patient and</p> <p>23 the reason the patient's seeing me. For someone that has</p> <p>24 a high risk of developing malignancies, that could be one</p>	<p style="text-align: right;">Page 61</p> <p>1 Q. And also I think you said for heavy smokers?</p> <p>2 Did you say that? Do you design screening programs for</p> <p>3 patients of yours that are heavy smokers?</p> <p>4 A. I follow guidelines for patients that have --</p> <p>5 that are heavy smokers.</p> <p>6 Q. Which guidelines do you follow?</p> <p>7 A. The recommendation to do low-dose CAT scan</p> <p>8 annually which is an accepted screening protocol. It's</p> <p>9 in NCCN and I think other places as well.</p> <p>10 Q. Are there any other categories of patients,</p> <p>11 your patients that you screen regularly?</p> <p>12 A. I'm not sure I -- I understand the question,</p> <p>13 how to answer the question. Every patient I'm seeing is</p> <p>14 being screened regularly.</p> <p>15 Q. Okay. Well, you mentioned that you've</p> <p>16 designed screening programs for patients. Are there any</p> <p>17 other categories of patients other than what we've just</p> <p>18 spoken about that you have designed screening programs</p> <p>19 for in your practice?</p> <p>20 A. Patients that have family -- that have had</p> <p>21 family histories and -- of -- of -- of genetic</p> <p>22 abnormalities in high risk cancer that they themselves</p> <p>23 haven't had but because there's unknown mutations or</p> <p>24 there have been unknown mutations that may put those</p>

<p style="text-align: right;">Page 62</p> <p>1 patients at risk, I will create a more intense screening 2 program for that group of patients than for somebody that 3 didn't have any of that history. 4 Q. Any other categories? 5 A. Not that I can think of. 6 Q. Okay. Scroll down to or move down to the 7 next paragraph. You say you're compensated for this 8 matter at an hourly rate. What is your hourly rate? 9 A. My hourly rate for reviewing records is \$500 10 per hour. For deposition or courtroom testimony it's 11 \$600 per hour. 12 Q. So you're getting paid \$600 an hour to be 13 here today? 14 A. I believe so, yes. 15 Q. Are you confirming that? Is that what you're 16 doing now? 17 A. No. 18 Q. What are you looking at -- is that your 19 report? 20 A. That's the -- my -- my report. 21 Q. Okay. You also state in that paragraph that 22 the opinions you "state in this report are stated within 23 a reasonable degree of professional certainty." What 24 does that mean?</p>	<p style="text-align: right;">Page 64</p> <p>1 duration of use." What is that assumption based on? 2 A. Based on the information I was provided by 3 counsel. 4 Q. What information was that? 5 A. Information we've already discussed. It was 6 the reports of their experts. 7 Q. So that assumption in Section 2 is based on 8 the reports of their experts; correct? 9 A. Correct. 10 Q. Anything else? 11 A. No. 12 Q. Okay. And you also assume "that the medical 13 monitoring fund/program to be established can be 14 efficiently administered to ensure that people will only 15 receive funding for appropriate tests or intervention." 16 What is that based on? 17 A. So my charge was to create a medical 18 monitoring program for a class of patients. When I put 19 that together, I have no knowledge as to how -- how these 20 types of things are funded or -- or arranged 21 logistically. I just know that -- what medically makes 22 sense and that's what I put together in my report. 23 MR. KERNER: Could you read that answer back, 24 please.</p>
<p style="text-align: right;">Page 63</p> <p>1 MS. GEMAN: You can take the time you need to 2 look at the language. 3 BY THE WITNESS: 4 A. I think that's going to be true of any 5 opinions I have about anything. Nothing is set in stone. 6 It's going to be within what I consider -- what's 7 considered reasonable based on my profession. 8 BY MR. KERNER: 9 Q. Tell me what you mean by "professional 10 certainty." 11 A. In other words, based on my medical expertise 12 rather than just assumptions, lay assumptions. 13 Q. Is professional certainty different than 14 medical certainty? 15 A. Probably not. 16 Q. Did someone tell you to use that phrase? 17 A. No. 18 Q. Have you ever used it before? 19 A. I can't -- I can't recall. 20 Q. If you go to the top of the next page, you 21 say that in forming your opinions you've "assumed that 22 the people who took the Valsartan in question can be 23 identified along with identification of the manufacturers 24 of their pills, the dosage and levels of NDMA/NDEA and</p>	<p style="text-align: right;">Page 65</p> <p>1 (Requested portion of the 2 record read.) 3 BY MR. KERNER: 4 Q. And when you say "what medically makes 5 sense," is that based on your review of the reports from 6 Plaintiffs' experts? 7 A. No. What medically makes sense is based on 8 my -- my development of what I consider to be appropriate 9 screening for the patients that are at risk. 10 Q. And what you consider to be appropriate for 11 screening is based on what? 12 A. Is based on my understanding of the diseases 13 and my review of the literature as outlined. 14 Q. I'm sorry. I didn't hear it. 15 A. As outlined in my report. 16 Q. What about any of the guidelines that are -- 17 the NCCN guidelines, was that something you considered? 18 A. Yes. 19 Q. Does your screening program here vary from 20 the NCCN guidelines? 21 A. The NCCN guidelines don't specifically 22 outline the screening program especially for this 23 particular class of patients. It just outlines details 24 about risks and how they should be monitored.</p>

<p style="text-align: right;">Page 66</p> <p>1 Q. In paragraph 3, "Background," you say: "It's 2 been established that Valsartan API manufactured by 3 certain manufacturers here and sold to other companies 4 was contaminated with carcinogens, NDMA and NDEA." Do 5 you see that? 6 A. Yes. 7 Q. And who established that? 8 A. I don't know who established that. I know 9 that it's been established based on the -- on the reports 10 that I was given. 11 Q. Okay. Anything else -- based on anything 12 else or just the reports that you were given? 13 A. Just on the reports that I was given. 14 Q. Okay. Now, a little further down in 15 paragraph 3 you mention that you constructed a monitoring 16 protocol. The first thing you did was identify certain 17 cancers; correct? 18 A. Correct. 19 Q. And you did that based on the review of four 20 Plaintiffs' experts; correct? 21 A. Correct. 22 Q. So how did you do that? Explain how you did 23 that, please. 24 A. Explain how I did what?</p>	<p style="text-align: right;">Page 68</p> <p>1 BY THE WITNESS: 2 A. Yes. 3 BY MR. KERNER: 4 Q. What's your basis for that opinion? 5 A. My basis for the opinion is the evidence 6 provided that suggests that these cancers are at 7 increased risk of patients that have had exposure to that 8 carcinogen and the levels they had exposure to, so they 9 deserve to be monitored for those. 10 Q. And again that's based on the four 11 Plaintiffs' experts that you referred to? 12 A. Correct. 13 Q. Is there potential for some of the proposed 14 class members to be excluded from the screening for one 15 or more of the nine cancers that you outlined? 16 MS. GEMAN: Objection to the extent it calls 17 for a legal conclusion. 18 BY THE WITNESS: 19 A. Could you repeat the question? 20 BY MR. KERNER: 21 Q. Sure. Is there a potential for some of these 22 proposed class members to be excluded from screening, to 23 not be screened for one or more of the nine cancers you 24 outlined?</p>
<p style="text-align: right;">Page 67</p> <p>1 Q. How you identified -- you said: "The 2 following cancers merit monitoring." You reviewed the 3 reports of these four experts, and what led you to 4 conclude that these nine cancers merited monitoring? 5 A. These nine cancers were identified as those 6 that were at higher risk based on the exposure to NDMA 7 and NDEA. 8 Q. By the experts that you relied on; correct? 9 A. Correct. 10 Q. Did you consider any other cancers? 11 A. No. 12 Q. So is it your opinion, Doctor, that every 13 proposed medical monitoring class member be screened for 14 each of these nine cancers? 15 A. The screening program that I outlined would 16 cover those nine cancers, nine classes of cancers. 17 Q. I understand that. We'll get to that 18 actually, but is it your testimony and is it your opinion 19 that all class members, proposed class members be 20 screened for all of the nine cancers? 21 A. Yes. 22 Q. Every single class member should be screened 23 for all nine cancers? 24 MS. GEMAN: Objection, asked and answered.</p>	<p style="text-align: right;">Page 69</p> <p>1 MS. GEMAN: Same objection. 2 BY THE WITNESS: 3 A. I don't understand -- I don't understand the 4 question. 5 BY MR. KERNER: 6 Q. Do you think there are any circumstances 7 where any of the potential class members wouldn't need to 8 be screened for all nine of these cancers? 9 MS. GEMAN: Objection. 10 BY THE WITNESS: 11 A. I think the basic screening is necessary for 12 every patient. I think individual patients would then 13 behoove us to look at different things based on that 14 patient, but the basic screening should be true for every 15 patient. 16 Q. Let's explore that. What would you look at 17 with respect to individual patients? 18 MS. GEMAN: Objection. 19 BY THE WITNESS: 20 A. You mean above and beyond the screening 21 program that's outlined? 22 MR. KERNER: Can you just read back his last 23 answer, please. 24</p>

<p style="text-align: right;">Page 70</p> <p>1 (Requested portion of the 2 record read.) 3 BY MR. KERNER: 4 Q. Okay, Doctor. You said it would behoove us 5 to look at different things for different patients. What 6 things would you look at? 7 A. Well, I think I mentioned in my report if 8 somebody was a heavy smoker I may focus also on diseases 9 associated with tobacco as I would do anyway even if they 10 hadn't had this exposure, but this exposure may increase 11 the risks that they have based on their own history, but 12 yet everybody deserves at least the basic screening 13 whatever their own history is. But any doctor's gonna 14 look at a patient's individual problem. Someone has a 15 pain in his arm, he's going to look at the arm. 16 Q. Sure. And different patients might require 17 different screening? 18 MS. GEMAN: Objection. 19 BY THE WITNESS: 20 A. No. Different patients may require 21 additional testing to the basic screening. 22 BY MR. KERNER: 23 Q. Is there any reason or could there be -- 24 Strike that.</p>	<p style="text-align: right;">Page 72</p> <p>1 recommend PSA? 2 A. Yes. 3 Q. What if they're 85 years old? 4 A. Depends on the clinical status of the 5 patient. If they're 85 and fit with a good performance 6 status, yes. 7 Q. Are there any male patients that you would 8 not recommend a PSA for? 9 A. Patient that declined to have it. Someone 10 that's had a -- No, strike that. I -- I can't think of 11 any other specific situations where I would not do PSA 12 unless there -- as we mentioned someone, that was 13 suffering from other medical conditions that would not 14 allow for expectation of longevity. 15 Q. What's the basis for performing a PSA on an 16 80-year old man? What's the data or the support for 17 that? 18 A. Since there's no data on patients that are 80 19 exposed to these carcinogens and since I have seen as 20 others have elderly patients who have developed very 21 aggressive prostate cancer and if caught early could 22 be -- could be given the chance not to have to suffer 23 from progressive metastatic disease, I would recommend 24 doing PSA even in those patients because of the unique</p>
<p style="text-align: right;">Page 71</p> <p>1 Would there be any reason that you can think 2 of based on medical history or comorbidities or anything 3 like that for an individual patient where you wouldn't 4 conduct the same screening for that patient? For 5 example, would you recommend a colonoscopy every five 6 years for someone who had a prior perforation? 7 MS. GEMAN: Objection. 8 BY THE WITNESS: 9 A. Well, as discussed before, a patient that's 10 had a comorbidity or a problem related to a test would 11 not be offered that test. 12 BY MR. KERNER: 13 Q. Sure. Okay. And say, for instance, giving 14 another example, you list prostate cancer here in number 15 6. What's the appropriate screening that you propose for 16 prostate cancer? 17 A. Well, first I would limit it to males. 18 Q. Okay. 19 A. The appropriate screening for prostate cancer 20 would include a history to determine if there's any 21 urinary symptoms, would include a physical examination 22 which would include prostate exam as part of a regular 23 physical and may include a blood test called a PSA. 24 Q. And if the person is 80 years old, would you</p>	<p style="text-align: right;">Page 73</p> <p>1 situation where they've been exposed to these 2 carcinogens. 3 Q. So you'd recommend a PSA for a fit 90-year 4 old man? 5 A. Most likely, yes. 6 Q. Okay. Are there any risks to the screening 7 procedures that you're proposing? 8 A. There are risks -- 9 MS. GEMAN: Objection. 10 BY THE WITNESS: 11 A. There are risks to everything. A blood draw, 12 the needle could break off, you could get infection, you 13 could have pain. Most of the things I'm recommending are 14 within the limits of accepted risk for general 15 population. 16 BY MR. KERNER: 17 Q. Are the risks the same for all individuals? 18 A. No, of course not. 19 Q. Why not? 20 A. Because someone that's had a perforation from 21 a colonoscopy may be at risk for that happening again. 22 Someone that has other conditions of the colon which you 23 didn't mention before like severe diverticulitis or 24 diverticulosis may not be a good candidate for some of</p>

<p style="text-align: right;">Page 74</p> <p>1 the screening. So, of course, every person has to be 2 evaluated individually. 3 Q. Okay. Are there cases where the risks will 4 outweigh the benefits? 5 A. We've already alluded to some of those, yes. 6 Q. And the answer's yes? 7 A. Yes. 8 Q. In paragraph 4 you talk about in conducting 9 the analysis you "assumed the Plaintiffs' experts are 10 correct that the levels, dosage and duration of use 11 were/are sufficient to increase one's risk of certain 12 cancers and to cause or contribute to causing cancers in 13 users," and you prepared this report consistent with 14 those assumptions. And you're relying on those 15 assumptions for your opinions in this report; correct? 16 A. Correct. 17 Q. In the next paragraph you say: "In order to 18 qualify for medical monitoring, class members must have 19 ingested a cumulative amount of NDMA from both the 20 Valsartan pills and their diet and they've reached the 21 lifetime cumulative exposures associated with 22 statistically significant increased risks in dietary and 23 other studies." Did I read that correctly? 24 A. Yes.</p>	<p style="text-align: right;">Page 76</p> <p>1 toxins, that they are in a class that may be at risk for 2 developing certain things. 3 Q. You say that's your assumption. What is that 4 assumption based on? 5 A. That's my understanding. 6 Q. What is that understanding based on? 7 A. What -- my knowledge of the English language. 8 Q. Okay. So is lifetime cumulative threshold a 9 term that you've used in your medical practice over the 10 years? 11 A. No. It's a term I've seen in the reports. 12 Q. And that's the first time you've seen it was 13 in this report? 14 A. Probably. 15 Q. Now you talk about the cumulative amount of 16 NDMA from both the Valsartan pills and their diet reached 17 a lifetime cumulative exposure. You see that in that 18 paragraph; right? 19 A. Can you repeat that, please. 20 Q. Sure. I'm sorry. In that same paragraph, 21 you talk about that "the class member must have ingested 22 a cumulative amount of NDMA from both the Valsartan pills 23 and their diet that they've reached lifetime cumulative 24 exposures." Do you see that?</p>
<p style="text-align: right;">Page 75</p> <p>1 Q. What is lifetime cumulative exposure? 2 A. The amount of exposure they've had to NDMA 3 and NDEA. 4 Q. Is that a term that you've used in your 5 medical practice over the years? 6 A. What's that? 7 Q. Lifetime cumulative exposure. 8 A. I've used that in regards to many things -- 9 exposure to tobacco, exposure to certain chemotherapeutic 10 drugs where the cumulative toxicity has to do with 11 lifetime exposure, a drug called Adriamycin. Your whole 12 life you're at certain risk if you've had cumulative 13 exposure, so yes, I use that term all the time. 14 Q. Are you familiar with the term lifetime 15 cumulative threshold? 16 A. I'm -- I know what that means but what do you 17 mean am I -- 18 Q. So you know what it means. What does it mean 19 to you? 20 A. Could you repeat the question? 21 Q. Lifetime cumulative threshold. 22 A. My assumption is that that means that when 23 someone's reached a certain level of exposure like with 24 radiation exposure, like with the drugs, like with these</p>	<p style="text-align: right;">Page 77</p> <p>1 A. I do. 2 Q. Is NDMA something that you can be exposed to 3 from your diet? 4 A. I believe that the nitrosamine -- the 5 nitrosamines you're exposed to in -- in certain food 6 types. 7 Q. What food types? 8 A. Prepared foods, coldcuts, bacon, things where 9 nitrates are used as preservative or naturally occurring. 10 Q. What about fresh fruit? 11 A. I'm not -- I'm not certain. 12 Q. Vegetables? 13 A. I don't know. 14 Q. How can you tell the level of NDMA -- Strike 15 that. 16 How can you tell whether the level of NDMA is 17 from the Valsartan pill or your diet? 18 A. I don't -- I don't know that you can tell. 19 Q. And are you familiar with indigenous NDMA? 20 A. Yes. 21 Q. What is that? 22 A. NDMA that's just present in the body. 23 Q. You don't mention that in your report? 24 A. No.</p>

<p style="text-align: right;">Page 78</p> <p>1 Q. Is indigenous NDMA, can that be part of a 2 lifetime cumulative exposure? 3 A. Yes. 4 Q. So it's the Valsartan pill, it's your diet 5 and it's the indigenous NDMA; correct -- 6 A. Correct. 7 MS. GEMAN: Objection, vague. 8 BY MR. KERNER: 9 Q. -- that are all -- that all can be part of 10 lifetime cumulative exposure as you used that term here 11 in your report; correct? 12 A. Correct. 13 Q. And am I correct that there's no way to 14 identify what percentage of NDMA comes from which 15 factor -- the Valsartan pill, the diet or the indigenous 16 NDMA? 17 A. I think and my understanding of the experts' 18 evaluation is that the amount of NDMA found in the vast 19 majority of people from indigenous or naturally occurring 20 substances is quite lower than from a toxic -- the toxic 21 levels that were found in the product that we're 22 discussing, so -- 23 Q. What -- sorry. 24 A. -- it's unlikely that somebody would have</p>	<p style="text-align: right;">Page 80</p> <p>1 reasonable degree of medical certainty that there exists 2 diagnostic tests that can mitigate the risks of 3 developing cancer faced by the class of people because of 4 their exposure to contaminated Valsartan who have a level 5 of exposure equal to the LTC and this program --" meaning 6 your program; correct? 7 A. Yes. 8 Q. "-- is different than the one that would have 9 been prescribed in the absence of that particular 10 exposure and increased risk." Did I read that correctly? 11 A. Yes. 12 Q. So a few things I want to talk to you about 13 in that sentence. You hold an opinion to a reasonable 14 degree of medical certainty that there are diagnostic 15 tests that mitigate the risk of developing cancer; 16 correct? 17 A. Correct. 18 Q. Now, you don't mean that there are tests that 19 can prevent you from developing cancer, do you? 20 A. There are. 21 Q. What are they? 22 A. Colonoscopy, for example. 23 Q. Any others? 24 A. Repeat -- can you repeat the question?</p>
<p style="text-align: right;">Page 79</p> <p>1 just from those other things enough exposure, enough 2 levels to render them at significant risk. While there's 3 so much more exposure from the tainted Valsartan, that 4 it's -- it makes it a much more important issue. 5 Q. What's your basis for that statement? 6 A. The experts' review of this. 7 Q. So other than the Plaintiffs' other experts 8 you have no idea what percentage of NDMA comes from 9 Valsartan, diet or indigenous production; correct? 10 A. Correct. 11 Q. And, by the way, with respect to lifetime 12 cumulative exposure, you have not independently evaluated 13 or determined the lifetime cumulative exposure for NDMA 14 or NDEA; correct? 15 A. That was not my -- my role in that. I have 16 not done that. 17 Q. So I'm correct? 18 A. Yes. 19 Q. Prior to this litigation -- Strike that. 20 Let's go to the bottom of Page 3, please, 21 your "Opinion on Medical Monitoring." Do you see that 22 paragraph? 23 A. Yes. 24 Q. You say that it's your "opinion to a</p>	<p style="text-align: right;">Page 81</p> <p>1 MR. KERNER: Can you read it back, please. 2 (Requested portion of the 3 record read.) 4 BY THE WITNESS: 5 A. Yes. Upper endoscopy, detection of Barrett's 6 esophagus, Pap smear, detection of pre-malignant changes. 7 Mammogram even can detect ductal carcinoma insitu or 8 other conditions that are considered pre-malignant. 9 Evaluation of the liver to look for cirrhosis can 10 predispose to the -- or fatty liver can be a precursor to 11 developing -- to developing hepatocellular cancer. 12 Evaluation of the pancreas can find -- can find certain 13 ductal cystic changes that may be precursors to cancer. 14 That's off the top of my head things that I can think of 15 where it would predict or even prevent cancer. 16 BY MR. KERNER: 17 Q. And you talk about class of people because of 18 their exposure to contaminated Valsartan? 19 A. Correct. 20 Q. And to that you're talking about people who 21 have an exposure greater than or equal to the LCT which 22 is a term you learned in your report for the first time? 23 A. Correct. 24 MS. GEMAN: Objection, misstates the</p>

<p style="text-align: right;">Page 82</p> <p>1 testimony.</p> <p>2 BY MR. KERNER:</p> <p>3 Q. You say: "This program is different than the</p> <p>4 one that would have been prescribed in the absence of</p> <p>5 that particular exposure." Can you -- can you tell me</p> <p>6 what that sentence means?</p> <p>7 A. The whole point of a medical monitoring</p> <p>8 program for people that have been exposed is that we're</p> <p>9 doing more than I would do with a normal, healthy person</p> <p>10 that just came in the office.</p> <p>11 Q. Okay. But what this says is that "The</p> <p>12 program is different than one that would have been</p> <p>13 prescribed in the absence of that particular exposure."</p> <p>14 I think you mean Valsartan; correct --</p> <p>15 A. Correct.</p> <p>16 Q. -- and increased risk?</p> <p>17 And you link that to the exposure being</p> <p>18 greater than or equal to the LCT; correct?</p> <p>19 A. Correct.</p> <p>20 Q. Do you know if it's possible to reach the LCT</p> <p>21 based on endogenous NDMA and diet without Valsartan?</p> <p>22 A. I do not know the answer to that, but as I</p> <p>23 stated in my report, I could modify my opinion. At this</p> <p>24 point I would think that if somebody does show that</p>	<p style="text-align: right;">Page 84</p> <p>1 testimony.</p> <p>2 MR. KERNER: Can you read back my question,</p> <p>3 please.</p> <p>4 (Requested portion of the</p> <p>5 record read.)</p> <p>6 MS. GEMAN: Vague as to --</p> <p>7 MR. KERNER: I will rephrase that.</p> <p>8 MS. GEMAN: Yeah.</p> <p>9 BY MR. KERNER:</p> <p>10 Q. If a patient reached the LCT without any</p> <p>11 Valsartan exposure, would you recommend the same program?</p> <p>12 MS. GEMAN: Objection, vague, incomplete</p> <p>13 hypothetical.</p> <p>14 BY THE WITNESS:</p> <p>15 A. I was not asked to consider that, but I think</p> <p>16 it's worth evaluating.</p> <p>17 BY MR. KERNER:</p> <p>18 Q. And you just said you're modifying your</p> <p>19 opinion. What were you modifying your opinion to?</p> <p>20 MS. GEMAN: Objection, misstates testimony.</p> <p>21 BY THE WITNESS:</p> <p>22 A. I didn't say I was modifying my opinion. I</p> <p>23 was saying I would -- I would likely include anybody that</p> <p>24 could be shown to -- as I said, someone that reached</p>
<p style="text-align: right;">Page 83</p> <p>1 they've reached the LCT wherever their exposure to the</p> <p>2 nitrosamines is that they would be appropriate for the</p> <p>3 screening tests that I --</p> <p>4 Q. Even without Valsartan?</p> <p>5 A. Yes. Yes.</p> <p>6 Q. And so you would -- you would agree with me</p> <p>7 then that it's possible to -- Strike that.</p> <p>8 You don't know whether it's possible to reach</p> <p>9 the lifetime cumulative threshold without Valsartan;</p> <p>10 correct?</p> <p>11 A. Correct.</p> <p>12 Q. And you have no idea; correct?</p> <p>13 A. From what I've read, it sounds like it's not</p> <p>14 likely to reach the levels that were reached with the</p> <p>15 Valsartan exposure.</p> <p>16 Q. And to be clear, when you say "from what I've</p> <p>17 read," it's from relying on Plaintiffs' other experts --</p> <p>18 A. Correct.</p> <p>19 Q. -- correct?</p> <p>20 But your opinion now it sounds like has been</p> <p>21 modified to now say that if you've reached the LCT</p> <p>22 without any Valsartan exposure, you would propose the</p> <p>23 same program; correct?</p> <p>24 MS. GEMAN: No. Objection, misstates the</p>	<p style="text-align: right;">Page 85</p> <p>1 those levels should have this monitoring, so if that</p> <p>2 level came from somewhere else, I don't see why I</p> <p>3 wouldn't include them in that.</p> <p>4 BY MR. KERNER:</p> <p>5 Q. And do you do that with your patients now?</p> <p>6 A. Do I do what?</p> <p>7 Q. Do you screen your patients with this kind of</p> <p>8 exposure now? Do you screen your patients the way you're</p> <p>9 describing it for anybody who has achieved this LCT?</p> <p>10 MS. GEMAN: Objection, vague.</p> <p>11 BY THE WITNESS:</p> <p>12 A. No, I have no way of monitoring that. I have</p> <p>13 no way of evaluating for that.</p> <p>14 BY MR. KERNER:</p> <p>15 Q. You have no way of evaluating what -- whether</p> <p>16 they reached the LCT?</p> <p>17 A. Routinely -- routinely testing for levels of</p> <p>18 nitrosamines in a person's body.</p> <p>19 Q. You're not aware of any test that can</p> <p>20 determine the lifetime cumulative threshold, are you?</p> <p>21 A. I'm not aware of clinically available tests</p> <p>22 to monitor for that.</p> <p>23 Q. And, again, to be specific, lifetime</p> <p>24 cumulative threshold of nitrosamine or NDMA --</p>

<p style="text-align: right;">Page 86</p> <p>1 A. Correct.</p> <p>2 Q. -- or NDEA; correct?</p> <p>3 MS. GEMAN: I was going to jump in to say can</p> <p>4 I have that question read. You were speaking very</p> <p>5 quickly. I'm sorry.</p> <p>6 (Requested portion of the</p> <p>7 record read.)</p> <p>8 MS. GEMAN: Objection.</p> <p>9 MR. KERNER: Read that back again, please.</p> <p>10 (Requested portion of the</p> <p>11 record read.)</p> <p>12 BY MR. KERNER:</p> <p>13 Q. Let's move on to Page 4. You talk about</p> <p>14 specialized testing in Section 2 there. Do you see that?</p> <p>15 A. Yes.</p> <p>16 Q. You talk about -- is it Galleri or Galleri?</p> <p>17 A. Galleri.</p> <p>18 Q. And you say that "early detection or similar</p> <p>19 liquid biopsy should be performed annually." On Page 5</p> <p>20 you again mention Galleri, and you say that "it has been</p> <p>21 shown to detect certain cancers such as pancreatic and</p> <p>22 esophageal cancer." Where is the -- what is the data to</p> <p>23 support annual Galleri testing?</p> <p>24 MS. GEMAN: Objection.</p>	<p style="text-align: right;">Page 88</p> <p>1 in August to allow Medicare to -- to insist that Medicare</p> <p>2 cover this testing because of its -- its ability to</p> <p>3 detect cancers earlier.</p> <p>4 MR. KERNER: Great. I move to strike that as</p> <p>5 nonresponsive.</p> <p>6 BY MR. KERNER:</p> <p>7 Q. My question is do you know of any guidelines</p> <p>8 or any organization that supports annual testing of</p> <p>9 Galleri.</p> <p>10 A. No.</p> <p>11 MS. GEMAN: Objection, asked and answered.</p> <p>12 MR. KERNER: Now it's been answered.</p> <p>13 BY MR. KERNER:</p> <p>14 Q. You mentioned that Galleri has been shown to</p> <p>15 detect certain cancers such as pancreatic and esophageal</p> <p>16 cancer; correct?</p> <p>17 A. Correct.</p> <p>18 Q. That's what it says.</p> <p>19 Okay. You also recommend Cologuard for colon</p> <p>20 cancer?</p> <p>21 A. Correct.</p> <p>22 Q. And you recommend colonoscopy every five</p> <p>23 years and an upper endoscopy every five years; correct?</p> <p>24 A. Correct.</p>
<p style="text-align: right;">Page 87</p> <p>1 BY THE WITNESS:</p> <p>2 A. The recommendation to do annual testing is</p> <p>3 based on my own program recommending screening, and I'm</p> <p>4 recommending the patient be seen by a physician at least</p> <p>5 annually, so I would include that as part of the routine</p> <p>6 blood tests and evaluations.</p> <p>7 Q. Right. And my question is a little</p> <p>8 different. Other than your own recommendation, and I</p> <p>9 appreciate that, what is the data that supports Galleri,</p> <p>10 Galleri's annual testing?</p> <p>11 MS. GEMAN: Vague.</p> <p>12 BY THE WITNESS:</p> <p>13 A. There's data that shows Galleri can detect</p> <p>14 cancers in earlier stages.</p> <p>15 BY MR. KERNER:</p> <p>16 Q. And is that part of any guidelines from NCCN</p> <p>17 or any other organization?</p> <p>18 A. No.</p> <p>19 Q. Do you know of any organization that</p> <p>20 recommends annual testing with Galleri?</p> <p>21 A. I know that the American Cancer Society</p> <p>22 has -- has suggested utilizing this test for evaluating</p> <p>23 patients, and they're involved in -- in co -- in</p> <p>24 sponsoring of a bill that -- that was brought to Congress</p>	<p style="text-align: right;">Page 89</p> <p>1 Q. So for every patient who has -- every patient</p> <p>2 on the planet who has achieved this LCT that you've</p> <p>3 learned of in this litigation for the first time, you</p> <p>4 want them to have a colonoscopy and an upper GI endoscopy</p> <p>5 every five years?</p> <p>6 MS. GEMAN: Objection, misstates the opinion,</p> <p>7 misstates testimony, misstates the report, calls for a</p> <p>8 legal conclusion by the class definition.</p> <p>9 BY MR. KERNER:</p> <p>10 Q. Is that correct?</p> <p>11 A. I don't understand.</p> <p>12 Q. Any class member, any proposed class member</p> <p>13 you're suggesting -- Strike that.</p> <p>14 You're recommending that every single</p> <p>15 proposed class member has a colonoscopy and an upper</p> <p>16 endoscopy every five years regardless of comorbidities,</p> <p>17 regardless of other past history; correct?</p> <p>18 A. My recommendations are guidelines that are</p> <p>19 recommendations for patients and their doctors to</p> <p>20 consider using, so that would be taken into account when</p> <p>21 deciding on that test.</p> <p>22 Q. So -- okay. I appreciate that. And so am I</p> <p>23 correct that you think ultimately the decision is to be</p> <p>24 made by the individual and his or her treating physician</p>

<p style="text-align: right;">Page 90</p> <p>1 as to what particular procedure is appropriate for them, 2 for that person? 3 A. I'm -- I'm outlining a guideline because of 4 the exposure that can help guide the patient and the 5 doctor in determining -- in determining whether to follow 6 exactly the guideline or make individual recommendations, 7 yes. 8 Q. And I didn't include the low-dose CT chest 9 scan annually. It's your recommendation that any 10 proposed class member has a CT scan once a year? 11 A. No, I don't believe I said that. 12 (Witness peruses document.) 13 Q. Page 4. 14 A. Okay. 15 Q. You do say that; correct? 16 A. Yes. I'm sorry. Because of the exposure 17 that put them at the same risk as someone who'd been a 18 smoker. 19 Q. And your opinion -- that's your opinion, that 20 the exposure to NDMA or nitrosamines puts them at the 21 same risk as a smoker? 22 A. Based on the estimate of exposure and risk of 23 lung cancer from that exposure, yes. 24 Q. On whose estimate? Based on whose estimate?</p>	<p style="text-align: right;">Page 92</p> <p>1 Q. Okay. I don't see any other screening 2 identified in your report. Do you -- do you think that 3 those are the -- are those the cancers that you would 4 screen for -- pancreatic, esophageal, colorectal and lung 5 cancer? 6 MS. GEMAN: Objection, misstates testimony, 7 asked and answered. 8 BY THE WITNESS: 9 A. There's two things there. There's -- the 10 first is that the Galleri, what you're reading is using 11 pancreatic and esophageal as examples. It's not listing 12 all the cancers it's screening for, and the reason it was 13 listed as examples is because there's not good 14 screening -- screening tests for detecting those early. 15 The Galleri could, but the Galleri's good for almost 16 every cancer. That's the point of the Galleri. The -- 17 the other thing is that's not the only testing. If you 18 look in my program, it includes the annual laboratory 19 studies, exam, history, and those that you're referring 20 to are just specialized testing in addition that I felt 21 was -- was appropriate in order to help detect cancer in 22 earlier stages. 23 BY MR. KERNER: 24 Q. Where in your report do you talk about</p>
<p style="text-align: right;">Page 91</p> <p>1 A. The Plaintiff experts that estimated the 2 relative risk of 1.05 to 3.3 for lung cancer. 3 Q. So, again, this is basically just based on 4 what the Plaintiffs' experts have opined; correct? 5 A. Correct. 6 Q. So, Doctor, what I see in your report is you 7 seem to be recommending in some form or another the 8 Galleri which you say can detect certain cancers such as 9 pancreatic and esophageal; correct? 10 A. Can you tell me where you're looking, please. 11 Q. Yeah. That's on Page 5. Under "Colonoscopy 12 and Fecal DNA testing" you mention that -- I'm sorry. 13 Under "Galleri" you mention that Galleri is known to 14 detect certain cancers such as pancreatic and esophageal. 15 Do you see that? 16 A. Yes. 17 Q. Okay. And you also have a section on 18 colonoscopy for detecting colon or rectal cancer; 19 correct? 20 A. Correct. 21 Q. And then you also discuss a little further up 22 I believe, and we just talked about it briefly, the CT 23 chest scan. Is that for lung cancer? 24 A. Yes.</p>	<p style="text-align: right;">Page 93</p> <p>1 screening for bladder cancer? 2 A. So I don't talk specifically about bladder 3 cancer. It's listed with the other cancers in here, and 4 that would be included in the history because there'll be 5 unique things to -- to patients that have bladder cancer. 6 In the physical examination, laboratory tests could 7 determine -- could be a way to screen for bladder along 8 with others and then the Galleri which can also detect 9 urinary tract cancers and other cancers in earlier 10 stages. 11 Q. And what about liver cancer? 12 A. And liver cancer as well. 13 Q. Galleri? 14 A. Galleri, but also the things we mentioned. 15 Liver cancer would have signs usually of cirrhosis or 16 hepatic steatosis, fatty liver, and that can be detected 17 by examinations and by laboratory tests and by history. 18 Q. And if you can help me out here. Which 19 laboratory tests in your report are you referring to with 20 respect to liver cancer? 21 A. Liver enzymes. 22 Q. Where is that? 23 A. 1C: "Laboratory tests to include blood 24 smear, basic chemistry profile which includes liver</p>

<p style="text-align: right;">Page 94</p> <p>1 enzymes, kidney function and other labs."</p> <p>2 Q. Okay. Doctor, in paragraph 6 or Section 6,</p> <p>3 you say midway through the paragraph that you "certify</p> <p>4 that the monitoring proposals detailed above have the</p> <p>5 potential to significantly improve the outcomes of</p> <p>6 patients that may be destined to develop malignancies due</p> <p>7 to their exposures and do not pose any significant risks</p> <p>8 or negative consequences." Do you see that?</p> <p>9 MS. GEMAN: Just object to the extent --</p> <p>10 MR. KERNER: Excuse me?</p> <p>11 MS. GEMAN: I just note that the report speaks</p> <p>12 for itself.</p> <p>13 MR. KERNER: Sure.</p> <p>14 MS. GEMAN: You're paraphrasing.</p> <p>15 BY MR. KERNER:</p> <p>16 Q. Well, what I read, did I read that correctly?</p> <p>17 A. Yes.</p> <p>18 Q. Okay. What do you mean by "I certify that</p> <p>19 the monitoring proposals have the potential to</p> <p>20 significantly improve the outcomes?" Are you</p> <p>21 guaranteeing it?</p> <p>22 MS. GEMAN: Objection.</p> <p>23 BY THE WITNESS:</p> <p>24 A. Is your question what do I mean by "certify"?</p>	<p style="text-align: right;">Page 96</p> <p>1 MS. GEMAN: Objection, vague.</p> <p>2 BY THE WITNESS:</p> <p>3 A. As I stated before, anything you do including</p> <p>4 a needle stick or walking in a room -- I didn't state</p> <p>5 that before; I'm stating it now -- has risks.</p> <p>6 Q. And that's all I'm asking, right.</p> <p>7 MS. GEMAN: Objection, calls for speculation.</p> <p>8 BY MR. KERNER:</p> <p>9 Q. Doctor, in your practice, have you ever</p> <p>10 concluded that any patient's cancer was caused by NDMA or</p> <p>11 NDEA?</p> <p>12 A. I've never had the opportunity to do that,</p> <p>13 no.</p> <p>14 Q. So the answer's no, you have not?</p> <p>15 MS. GEMAN: Objection, asked and answered.</p> <p>16 BY THE WITNESS:</p> <p>17 A. No.</p> <p>18 BY MR. KERNER:</p> <p>19 Q. Over the course of your career how many</p> <p>20 patients have you treated ballpark?</p> <p>21 A. 20,000 to 30,000.</p> <p>22 Q. Out of that universe of patients, how many of</p> <p>23 them were cancer patients?</p> <p>24 A. Eighty percent.</p>
<p style="text-align: right;">Page 95</p> <p>1 BY MR. KERNER:</p> <p>2 Q. Yes, sir.</p> <p>3 A. It means that to the best of my medical</p> <p>4 knowledge and ability I believe that this does what it's</p> <p>5 stated to do.</p> <p>6 Q. It's your opinion?</p> <p>7 A. Correct.</p> <p>8 Q. Did somebody tell you to use the word</p> <p>9 "certify" in there?</p> <p>10 A. No.</p> <p>11 Q. You also say that: "These exposures do not</p> <p>12 pose any --" I'm sorry. "This monitoring proposal do not</p> <p>13 pose any significant risks or negative consequences."</p> <p>14 MS. GEMAN: Objection. Again, it misstates</p> <p>15 the report. It says: "As detailed in Dr. Catenacci's</p> <p>16 report."</p> <p>17 MR. KERNER: Yes.</p> <p>18 BY THE WITNESS:</p> <p>19 A. There's a report that's been stricken, and</p> <p>20 the details of that report is what I was addressing.</p> <p>21 BY MR. KERNER:</p> <p>22 Q. But we would agree, I think you've already</p> <p>23 agreed, that there could be risks or negative</p> <p>24 consequences to certain procedures; correct?</p>	<p style="text-align: right;">Page 97</p> <p>1 Q. Okay. Out of that number, how many of those</p> <p>2 patients did you make a determination as to the actual</p> <p>3 cause of their cancer?</p> <p>4 A. I'm actually not in the habit of making</p> <p>5 determination as to cause of cancers usually.</p> <p>6 Q. And you're not opining here about causation</p> <p>7 of any of the proposed class members; correct?</p> <p>8 A. Correct.</p> <p>9 Q. In your report on Page 4, in C you talk about</p> <p>10 "Periodic testing." Do you see that?</p> <p>11 A. Yes.</p> <p>12 Q. And for the colonoscopy you do say every five</p> <p>13 years as for screening in moderately high risk patients?</p> <p>14 A. Correct.</p> <p>15 Q. What makes a patient moderately high risk?</p> <p>16 A. I believe that's outlined in the NCCN</p> <p>17 guidelines, but moderately high risk patients would be</p> <p>18 somebody that had had a polyp, a pre-malignant polyp, an</p> <p>19 adenomatous polyp. I think that would be the main</p> <p>20 definition.</p> <p>21 Q. With the proposed class members, have you</p> <p>22 considered in your program the likelihood of reduced</p> <p>23 mortality?</p> <p>24 A. Could you --</p>

<p style="text-align: right;">Page 98</p> <p>1 Q. Are you considering whether the screening is 2 appropriate? 3 A. Could you repeat the question? 4 MR. KERNER: Can you read it back, please. 5 (Requested portion of the 6 record read.) 7 BY THE WITNESS: 8 A. I believe by definition of what we're doing 9 the point is to reduce mortality and morbidity. 10 BY MR. KERNER: 11 Q. And do we have -- do you have, Doctor, any 12 specific data for each of the tests that you're proposing 13 on whether it, in fact, does that? 14 A. Not specifically, no. 15 Q. This is just your -- Well, strike that. 16 Okay. 17 A. Could we go back to that last question? 18 Q. Sure. 19 THE WITNESS: Can you read that back? 20 (Requested portion of the 21 record read.) 22 BY THE WITNESS: 23 A. I mean there is data, for example, with 24 low-dose CAT scans for lung cancer that it does reduce</p>	<p style="text-align: right;">Page 100</p> <p>1 BY MR. KERNER: 2 Q. Sure. You can't point to any medical 3 literature or authoritative source that has actually 4 determined that exposure to NDMA or NDEA reasonably 5 necessitates the kind of medical monitoring for cancer in 6 humans, can you? 7 MS. GEMAN: Objection. 8 BY THE WITNESS: 9 A. I haven't investigated that. I know 10 literature exists because the reports that have come out 11 were based on it. Plus I know the FDA withdrew the drug 12 in a -- in a rapid manner because of their determination 13 there was some risk. That's all I know. 14 BY MR. KERNER: 15 Q. Okay. So but my question is are you aware of 16 any medical literature or authoritative source that 17 determined the kind of medical monitoring that you're 18 proposing for cancer in humans is appropriate for -- 19 because of exposure to NDMA or NDEA. 20 MS. GEMAN: Objection, asked and answered, 21 vague. 22 BY THE WITNESS: 23 A. There's medical literature to support the 24 monitoring for patients at risk, at similar risk to what</p>
<p style="text-align: right;">Page 99</p> <p>1 morbidity and mortality by detecting cancer earlier, so 2 there is data. You asked if I specifically had data for 3 this, so that's the answer. 4 MR. KERNER: Okay. I actually need to take a 5 two-minute comfort break, and we'll come right back. 6 THE VIDEOGRAPHER: The time now is 11:34 a.m. 7 This is the end of media four. We're off the record. 8 (WHEREUPON, a break was 9 taken.) 10 The time is now 11:56 a.m. This is the 11 beginning of media five. We're back on the record. 12 BY MR. KERNER: 13 Q. Dr. Kaplan, we're not quite there yet, so 14 we're going to just keep chugging along. All right? 15 A. Yes, sir. 16 Q. All right. A few questions here. 17 You can't point to any medical literature or 18 authoritative source that has actually determined that 19 exposure to NDMA or NDEA reasonably necessitates any sort 20 of medical monitoring for cancer in humans, can you? 21 MS. GEMAN: Objection. 22 BY THE WITNESS: 23 A. Can you repeat that, please. 24</p>	<p style="text-align: right;">Page 101</p> <p>1 we've determined or what has been determined for the risk 2 for the specific agents but no, not literature 3 specifically that I know of addressing that and the 4 monitoring. 5 BY MR. KERNER: 6 Q. And by "that" you mean NDMA and NDEA? 7 A. NDMA and NDEA, correct. 8 Q. So the answer to my question is no, you're 9 not aware of any medical literature or authoritative 10 source that determined medical monitoring for NDMA -- as 11 a result of NDMA and NDEA exposure is appropriate -- 12 MS. GEMAN: Objection. 13 BY MR. KERNER: 14 Q. -- correct? 15 A. I've never seen literature that -- yes. 16 MR. KERNER: Did you get that? 17 THE REPORTER: Yes. 18 MR. KERNER: I just saw you tilt your head. 19 BY MR. KERNER: 20 Q. Doctor, you're not offering any specific 21 criticisms or opinions about what a specific Defendant 22 did or didn't do with respect to Valsartan, are you? 23 A. I'm not opining to that, no. 24 Q. And you're not offering any opinion that NDMA</p>

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<p>1 or NDEA causes cancer, are you?</p> <p>2 A. I'm not being asked to opine to that.</p> <p>3 Q. So you're not?</p> <p>4 A. I'm using that assumption.</p> <p>5 Q. But you -- you're not offering the opinion</p> <p>6 that NDMA or NDEA causes cancer; correct?</p> <p>7 A. I'm suggesting that that's a truism which is</p> <p>8 why I've created this monitoring, so I guess I'm offering</p> <p>9 that opinion based on -- I'm offering that as a statement</p> <p>10 of fact.</p> <p>11 Q. Based on what?</p> <p>12 A. Based on the reports I've read.</p> <p>13 Q. You haven't independently assessed the</p> <p>14 carcinogenicity of NDMA or NDEA; correct?</p> <p>15 A. Correct, I have not independently assessed</p> <p>16 any of that.</p> <p>17 Q. And you're not offering any opinion that</p> <p>18 Defendants' Valsartan products cause cancer; correct?</p> <p>19 A. Could you repeat that, please.</p> <p>20 Q. Sure. I'm going to do it this way. You</p> <p>21 haven't independently assessed the -- whether or not the</p> <p>22 Defendants' Valsartan products cause cancer?</p> <p>23 A. I have not independently assessed that.</p> <p>24 Q. So you won't be opining on that; correct?</p>	<p>1 you it is, and I know we discussed this off the record.</p> <p>2 I don't want to take a lot of time.</p> <p>3 And, Doctor, I just want to make sure.</p> <p>4 You've told me all of your opinions that you hold with</p> <p>5 respect to the case now; correct?</p> <p>6 A. I've -- all that I've been asked about, yes.</p> <p>7 Q. Well, are there other opinions that you hold</p> <p>8 that you are going to testify to?</p> <p>9 A. Not that I know of.</p> <p>10 Q. Okay. And so we've discussed the facts that</p> <p>11 support those opinions; correct?</p> <p>12 A. Correct.</p> <p>13 Q. And you feel like you've had a chance to</p> <p>14 state your opinions during this deposition?</p> <p>15 MS. GEMAN: Objection.</p> <p>16 BY THE WITNESS:</p> <p>17 A. Yes.</p> <p>18 MR. KERNER: Okay. I'm going to pass the</p> <p>19 witness now.</p> <p>20 MS. ISIDRO: Are there others on the Zoom who</p> <p>21 would like to ask any questions?</p> <p>22 MS. LOTMAN: Yes. This is Alyson Lotman. I'm</p> <p>23 going to have a few. Give me one minute.</p> <p>24 MS. GEMAN: Alyson, can you state your</p>
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<p>1 A. I won't be opining on -- I won't -- I</p> <p>2 really --</p> <p>3 MS. GEMAN: Do you understand the question?</p> <p>4 MR. KERNER: Yeah.</p> <p>5 MS. GEMAN: Answer it.</p> <p>6 BY THE WITNESS:</p> <p>7 A. Well, not exactly. I'm not specifically</p> <p>8 looking at the data to opine that the drugs with the</p> <p>9 contaminants have led to cancer, but I'm using others who</p> <p>10 have done that in order to -- to justify and create my</p> <p>11 program.</p> <p>12 BY MR. KERNER:</p> <p>13 Q. I understand that. And the others, again, I</p> <p>14 want to be specific, are the Plaintiffs' experts --</p> <p>15 A. Correct.</p> <p>16 Q. -- correct?</p> <p>17 Doctor, I'm going to move -- I'm going to end</p> <p>18 my testimony -- end my questioning for the time being,</p> <p>19 but a couple of ministerial things first.</p> <p>20 Rachel, as we talked about, we've got -- I</p> <p>21 want to mark as Exhibit 4 the thumb drive that we</p> <p>22 discussed which contains the files that you produced on</p> <p>23 Monday. So we'll mark that as Exhibit 4. You can review</p> <p>24 it. You can look at it to make sure it is what we tell</p>	<p>1 appearance and which Defendant you represent and firm?</p> <p>2 This is Rachel Geman speaking. Thank you.</p> <p>3 MS. LOTMAN: Alyson Lotman from Duane Morris.</p> <p>4 I represent the HP Defendants.</p> <p>5 I apologize. If someone else has a few,</p> <p>6 wants to go before me. I'm just trying to close some</p> <p>7 screens before I can get on.</p> <p>8 Are we still on the record?</p> <p>9 THE VIDEOGRAPHER: Yes.</p> <p>10 MR. KERNER: Yes.</p> <p>11 MS. GEMAN: Yes.</p> <p>12 MS. LOTMAN: Thanks.</p> <p>13 Good afternoon, Dr. Kaplan. Can you hear</p> <p>14 me and see me okay?</p> <p>15 THE WITNESS: I can hear you. You're a little</p> <p>16 picture up there, yeah.</p> <p>17 MS. LOTMAN: It might be better that way.</p> <p>18 THE WITNESS: I'd rather not look at myself</p> <p>19 so.</p> <p>20 MS. LOTMAN: I understand that feeling.</p> <p>21 Happens to me a lot when I'm on Zoom.</p> <p>22 A few questions for you then, Doctor.</p> <p>23</p> <p>24</p>

<p style="text-align: right;">Page 106</p> <p>1 CROSS EXAMINATION</p> <p>2 BY MS. LOTMAN:</p> <p>3 Q. How long did it take for you to develop this</p> <p>4 plan, medical monitoring plan in your report?</p> <p>5 A. I would say about -- about a month, three or</p> <p>6 four weeks.</p> <p>7 Q. Okay. And over the course of that time how</p> <p>8 many -- how many hours do you think you actually spent on</p> <p>9 it?</p> <p>10 A. It should be documented. I think it was</p> <p>11 probably about 12 to -- probably about 20 hours.</p> <p>12 Q. Okay. And that includes -- does that include</p> <p>13 reviewing literature?</p> <p>14 A. Yes.</p> <p>15 Q. And writing the report itself?</p> <p>16 A. Correct.</p> <p>17 Q. How long do you think it took you to actually</p> <p>18 formulate your opinions?</p> <p>19 MS. GEMAN: Objection.</p> <p>20 BY THE WITNESS:</p> <p>21 A. Ten, twelve hours.</p> <p>22 BY MS. LOTMAN:</p> <p>23 Q. And, Doctor, have you ever -- have you ever</p> <p>24 crafted a medical monitoring plan such as this for</p>	<p style="text-align: right;">Page 108</p> <p>1 BY MS. LOTMAN:</p> <p>2 Q. Let me reask it --</p> <p>3 A. Okay.</p> <p>4 Q. -- because I think it's a little unclear.</p> <p>5 You have patients who have cancer at your practice;</p> <p>6 right?</p> <p>7 A. Correct.</p> <p>8 Q. Do you have patients who have certain genetic</p> <p>9 issues or mutations or elements that you are concerned</p> <p>10 about like BRCA?</p> <p>11 A. Do I -- I couldn't hear you.</p> <p>12 Q. You also treat -- sorry. You also treat</p> <p>13 patients who have certain genetics like BRCA that you</p> <p>14 treat as well, you're monitoring?</p> <p>15 A. Yes.</p> <p>16 Q. Are there any other types of patients that</p> <p>17 you see?</p> <p>18 A. Yes.</p> <p>19 Q. Okay. What are they or who are they?</p> <p>20 A. You want their names and phone numbers?</p> <p>21 Q. No, Doctor. I'm just looking for what is</p> <p>22 their concern that they're seeing an oncologist.</p> <p>23 A. So I happen to have a handful of patients</p> <p>24 that do not see me for oncology, that see me for internal</p>
<p style="text-align: right;">Page 107</p> <p>1 litigation before?</p> <p>2 A. No.</p> <p>3 Q. Have you ever published on medical</p> <p>4 monitoring?</p> <p>5 A. I have not.</p> <p>6 Q. Then, Doctor, you talked before about you</p> <p>7 have your private practice. You have patients who are</p> <p>8 asymptomatic but they have certain genetic issues like</p> <p>9 BRCA; right?</p> <p>10 A. Correct.</p> <p>11 Q. And so you are conducting additional</p> <p>12 monitoring because of that genetic issue; right?</p> <p>13 A. Correct.</p> <p>14 Q. Okay. For patients who -- do you see any</p> <p>15 other patients who are asymptomatic who don't have</p> <p>16 genetic issues?</p> <p>17 A. Could you -- could you rephrase it? Do I see</p> <p>18 any patients?</p> <p>19 Q. Sure. Sure. So do you also have any other</p> <p>20 patients who treat with you who are asymptomatic but did</p> <p>21 not have a prior cancer who do not have genetic issues?</p> <p>22 MS. GEMAN: Objection, vague.</p> <p>23 BY THE WITNESS:</p> <p>24 A. Do I have --</p>	<p style="text-align: right;">Page 109</p> <p>1 medicine either because they were related to a member of</p> <p>2 the family that I took care of or I know them from the</p> <p>3 community or from other people, so I do have some general</p> <p>4 internal medicine patients but not very many. I don't</p> <p>5 consider myself a general internist, but you have to be</p> <p>6 to some degree a general internist in order to be a</p> <p>7 medical oncologist. I do see patients that have had</p> <p>8 abnormal findings, for example, Barrett's esophagus</p> <p>9 or -- well, we mentioned genetic like Lynch syndrome,</p> <p>10 people have had multiple polyps that haven't been</p> <p>11 identified as having a genetic -- a genetic condition</p> <p>12 that's been identified. I do follow patients that have</p> <p>13 had variants of the genetic -- like the BRCA that are</p> <p>14 variants of uncertain significance and so they'll be</p> <p>15 monitored to a certain degree, not the same as a known</p> <p>16 deleterious mutation or known risk mutation but the</p> <p>17 possibility that it is going to be identified as one, so</p> <p>18 they're -- they're followed, and then other patients are</p> <p>19 just concerned. I've had people come in that are just</p> <p>20 concerned about their cancer risk, and I also take care</p> <p>21 of some patients with blood disorders.</p> <p>22 Q. Okay. Doctor, for your patients who smoke,</p> <p>23 you follow the USPSTF guidelines for screening?</p> <p>24 A. I do.</p>

<p style="text-align: right;">Page 110</p> <p>1 Q. Are you aware that tobacco is a known human 2 carcinogen? 3 A. I am. 4 Q. Okay. And you don't recommend any extra 5 screening for those patients who have exposures to 6 tobacco? 7 A. No, I do. I -- I recommend a number of 8 screening procedures for them, mostly the things we've 9 outlined before -- the annual exams or blood tests, urine 10 tests. 11 Q. But you don't go to the same specialized plan 12 that you do for the patients in this case? 13 MS. GEMAN: Objection. 14 BY THE WITNESS: 15 A. I have not developed a specialized program 16 for that group of patients at this time. 17 BY MS. LOTMAN: 18 Q. So you treat patients who have exposure to 19 tobacco, a known human carcinogen, and you don't 20 recommend that they have the same types of tests, the 21 specialized testing that you've recommended for the 22 patients who have alleged exposure to nitrosamines? 23 MS. GEMAN: Objection, misstates the 24 testimony.</p>	<p style="text-align: right;">Page 112</p> <p>1 A. Not yet, no. But many tests that we do don't 2 have FDA approval, blood tests in the office, other 3 things, but yeah, you're right. It does not yet have FDA 4 approval. They're attempting to get FDA approval. 5 Q. Doctor, do you know the difference between a 6 known human carcinogen and a probable human carcinogen? 7 A. I'm assuming a known human carcinogen has 8 been proven to cause cancer. Usually -- I mean in humans 9 most of the probable human carcinogens are based on 10 animal studies and epidemiologic studies. 11 Q. Okay. Do you know what a probable human 12 carcinogen is? 13 A. So I'm saying probable is something that's 14 been shown in, probably in animal studies to increase 15 risk of cancer and to suggest that there's a human risk 16 as well. 17 Q. Suggest not -- not a -- not know? 18 A. I'm sorry? 19 Q. You said suggest and probable; right, for the 20 probable one? There's not a known carcinogen? There's a 21 difference; right? 22 A. Well, known human carcinogen may be a proven 23 carcinogen in the laboratory or in animal studies. 24 Q. Okay. Would you make the same about say</p>
<p style="text-align: right;">Page 111</p> <p>1 BY THE WITNESS: 2 A. I don't have a class program for those 3 patients I've -- that I've recommended. I don't have 4 large enough numbers that I'm seeing, and I haven't been 5 asked to do that. 6 BY MS. LOTMAN: 7 Q. So for your patients who smoke, you don't 8 have them go through the Galleri? They don't have 9 Galleri testing, do they? 10 A. No, but that's something that I intend to 11 start doing. 12 Q. When do you intend to start doing that? 13 A. Soon. I've already ordered the test a few 14 times. I've recently learned about the test and 15 evaluated its usefulness and have learned more about it, 16 and so I'm starting to order it or recommend it for 17 patients. 18 Q. How do you order it? 19 A. It's a prescription. It's a kit. You draw 20 blood and you send it off in a kit to the company. 21 Q. Does Galleri currently have FDA approval? 22 A. Galleri does not yet have FDA approval. It 23 does have CLIA certification. 24 Q. But does not have FDA approval?</p>	<p style="text-align: right;">Page 113</p> <p>1 medical monitoring for a probable human carcinogen as you 2 would for a known human carcinogen? 3 MS. GEMAN: Objection, incomplete 4 hypothetical. 5 BY THE WITNESS: 6 A. I haven't thought of that, so I don't have an 7 answer. 8 MS. LOTMAN: Okay. Those are all of my 9 questions. 10 Thank you very much for your time, Doctor. 11 THE WITNESS: Sure. 12 MR. KERNER: Anybody else have any questions? 13 (No response.) 14 Well, if nobody else has any questions, I 15 do very quickly. 16 I just want to mark another exhibit. 17 (Exhibit No. 5 marked as 18 requested.) 19 MS. GEMAN: This is 5. 20 MR. KERNER: This is 5. For the Zoom folks, 21 it says "Invoices." 22 MS. GEMAN: So in my copy it's three -- yeah, 23 it's three identical pages of October 22nd. 24 THE WITNESS: I have the same thing. Oh, it's</p>

<p style="text-align: right;">Page 114</p> <p>1 October 7th -- I mean November 7th to November 10th.</p> <p>2 MR. KERNER: Okay. Let's do it this way.</p> <p>3 MS. ISIDRO: Go off the record.</p> <p>4 MR. KERNER: Yeah. Let's go off the record</p> <p>5 for a second.</p> <p>6 THE VIDEOGRAPHER: The time now is 12:15.</p> <p>7 This is the end of media five. We're off the record.</p> <p>8 (WHEREUPON, a break was</p> <p>9 taken.)</p> <p>10 The time is 12:17 p.m. This is the</p> <p>11 beginning of media six. We're back on the record.</p> <p>12 REDIRECT EXAMINATION</p> <p>13 BY MR. KERNER:</p> <p>14 Q. Okay, Doctor. We just wanted to mark Exhibit</p> <p>15 5 and talk about them real quickly. Can you tell us what</p> <p>16 Exhibit 5 is?</p> <p>17 A. My invoices to -- to the lawyers.</p> <p>18 Q. And how many invoices are there?</p> <p>19 A. There are four in front of me.</p> <p>20 Q. Okay. And they're all addressed to Nicholas</p> <p>21 Migliaccio?</p> <p>22 A. Correct.</p> <p>23 Q. Does that sound right?</p> <p>24 A. Correct.</p>	<p style="text-align: right;">Page 116</p> <p>1 BY MR. KERNER:</p> <p>2 Q. Okay. Fair enough. So you -- on October</p> <p>3 22nd, 2001 you sent an invoice for a retainer of \$2,000?</p> <p>4 MS. GEMAN: 2021 not 2001.</p> <p>5 MR. KERNER: Oh, gosh, yeah. October 22nd,</p> <p>6 2021.</p> <p>7 MS. GEMAN: We're not that slow.</p> <p>8 BY MR. KERNER:</p> <p>9 Q. And that was for \$2,000; correct?</p> <p>10 A. Correct.</p> <p>11 Q. Has that been paid?</p> <p>12 A. Yes.</p> <p>13 Q. And then the next invoice is November 5th,</p> <p>14 2021 and that looks to be for time spent from</p> <p>15 October 20th to November 5th, and you spent 20 hours</p> <p>16 during that time frame for teleconferences and</p> <p>17 communication, review of literature, analyses and report</p> <p>18 review; correct?</p> <p>19 A. Correct.</p> <p>20 Q. Okay. And you billed that out at \$450 an</p> <p>21 hour?</p> <p>22 A. Correct.</p> <p>23 Q. And so the invoice is for \$11,250; correct?</p> <p>24 A. Correct.</p>
<p style="text-align: right;">Page 115</p> <p>1 Q. Who is that?</p> <p>2 A. It's the attorney that is -- one of the</p> <p>3 attorneys involved in this case.</p> <p>4 Q. Okay. But he's not the one who contacted you</p> <p>5 initially?</p> <p>6 A. No, I think he's the first one that I spoke</p> <p>7 to or one of the first ones that I spoke to. I can't</p> <p>8 recall.</p> <p>9 Q. Okay. So it was not at Lieff Cabraser as you</p> <p>10 testified earlier?</p> <p>11 MS. GEMAN: Objection, misstates testimony.</p> <p>12 BY THE WITNESS:</p> <p>13 A. She's one of the attorneys also that I -- I</p> <p>14 didn't remember who it was that contacted me first, but</p> <p>15 she's one that's been on all of our meetings.</p> <p>16 BY MR. KERNER:</p> <p>17 Q. But Mr. Migliaccio was the first one to</p> <p>18 contact you?</p> <p>19 MS. GEMAN: Objection.</p> <p>20 BY THE WITNESS:</p> <p>21 A. I don't recall exactly who was the first one</p> <p>22 to contact. That's the one who I was told to send the</p> <p>23 invoices to.</p> <p>24</p>	<p style="text-align: right;">Page 117</p> <p>1 Q. Was that paid?</p> <p>2 A. Yes, I believe so.</p> <p>3 Q. And the third invoice is five days later</p> <p>4 dated November 10th, and that was for time spent from</p> <p>5 November 7th to November 10th of 2021; correct?</p> <p>6 A. Correct.</p> <p>7 Q. And that also was for teleconferences and</p> <p>8 communication, review of literature, analyses and report</p> <p>9 review and writing and correcting reports; correct?</p> <p>10 A. Correct.</p> <p>11 Q. And you spent 11 hours?</p> <p>12 A. Correct.</p> <p>13 Q. Also billed out at \$450 an hour. I guess</p> <p>14 there's a .25 percent charge added onto it?</p> <p>15 A. Right.</p> <p>16 Q. What's that?</p> <p>17 A. It was because it was -- there was a time</p> <p>18 limit. It was rushed, not rushed, but there was a</p> <p>19 deadline to get it in, so I had to work within a shorter</p> <p>20 time frame.</p> <p>21 Q. Got it. And, by the way, the prior invoice</p> <p>22 on November 5th had that same --</p> <p>23 A. Correct.</p> <p>24 Q. -- .25 percent?</p>

<p style="text-align: right;">Page 118</p> <p>1 A. Correct.</p> <p>2 Q. So this third invoice was for \$6,187.50, also</p> <p>3 billed out at \$450 an hour; correct?</p> <p>4 A. Correct.</p> <p>5 Q. And the final invoice that we have is dated</p> <p>6 December 31st, 2021 for time spent from December 16th to</p> <p>7 December 31st for teleconference and review of records;</p> <p>8 correct?</p> <p>9 A. Correct.</p> <p>10 Q. What records did you review?</p> <p>11 A. I don't know the exact records. It's all the</p> <p>12 references that we had. It was discussing my report with</p> <p>13 the lawyers. I can't remember specifically.</p> <p>14 Q. Okay. And you spent 11 hours according to</p> <p>15 the invoice?</p> <p>16 A. Correct.</p> <p>17 Q. And there was no .25 percent charge on this</p> <p>18 one; correct?</p> <p>19 A. Correct.</p> <p>20 Q. And so the total amount due was 5500?</p> <p>21 A. Correct.</p> <p>22 Q. Has that been paid?</p> <p>23 A. I don't think so. I don't -- I don't</p> <p>24 remember.</p>	<p style="text-align: right;">Page 120</p> <p>1 Q. An extra 50 bucks an hour?</p> <p>2 A. Yeah.</p> <p>3 MR. KERNER: Okay. That's all I have.</p> <p>4 THE WITNESS: Okay.</p> <p>5 MR. KERNER: Anybody else has anything, speak</p> <p>6 now.</p> <p>7 MR. GEOPPINGER: Yeah, I have a couple</p> <p>8 questions, if I may. Good afternoon, Doctor. My name is</p> <p>9 Jeff Geoppinger. I'm here on behalf of Amerisource</p> <p>10 Bergen. Can you see me now?</p> <p>11 THE WITNESS: Sort of, yes.</p> <p>12 MR. GEOPPINGER: Good afternoon. Again, my</p> <p>13 name is Jeff Geoppinger. I represent Amerisource Bergen</p> <p>14 in this litigation. I just have a real quick couple</p> <p>15 follow-up questions.</p> <p>16 CROSS EXAMINATION</p> <p>17 BY MR. GEOPPINGER:</p> <p>18 Q. Earlier when you were talking to Ms. Lotman,</p> <p>19 you mentioned you have patients who you treat who are</p> <p>20 just concerned about cancer risk. Did I hear that</p> <p>21 correctly?</p> <p>22 A. Yes.</p> <p>23 Q. Are those patients asymptomatic?</p> <p>24 A. I think many of them are. There aren't a lot</p>
<p style="text-align: right;">Page 119</p> <p>1 Q. Okay. So -- so overall it looks as though</p> <p>2 you spent 44 hours --</p> <p>3 A. Okay.</p> <p>4 Q. -- correct?</p> <p>5 And you charged approximately \$24,000 and</p> <p>6 change; correct?</p> <p>7 A. Okay. I hadn't added it up.</p> <p>8 Q. Will you be providing any additional invoices</p> <p>9 for time since December 31st?</p> <p>10 A. Yes.</p> <p>11 Q. Do you have any idea how many hours you've</p> <p>12 spent since then?</p> <p>13 A. In preparing for the deposition, probably</p> <p>14 another 20 hours --</p> <p>15 Q. And --</p> <p>16 A. -- including the deposition.</p> <p>17 Q. Including the deposition.</p> <p>18 Okay. And I think you told us your rate for</p> <p>19 the deposition was \$600 an hour?</p> <p>20 A. Correct.</p> <p>21 Q. By the way, I note that on the last invoice</p> <p>22 dated December 31st you billed 11 hours at \$500 an hour,</p> <p>23 so your rate went up from November 10th to December 16th?</p> <p>24 A. Inflation.</p>	<p style="text-align: right;">Page 121</p> <p>1 of them in that category, but there are some who are</p> <p>2 asymptomatic.</p> <p>3 Q. I understand. They don't have an active</p> <p>4 cancer diagnosis; correct?</p> <p>5 A. Correct.</p> <p>6 Q. And they don't have any genetic conditions</p> <p>7 that would predispose them to cancer that they're</p> <p>8 concerned about or that you're concerned about; correct?</p> <p>9 A. None that had been identified, yes.</p> <p>10 Q. Okay. So for those patients, what do you do</p> <p>11 to treat them?</p> <p>12 A. So they're not being treated. They're being</p> <p>13 monitored, and it includes basic -- basic exam, something</p> <p>14 they may get from their internist but with more focus on</p> <p>15 cancers.</p> <p>16 Q. And is that screening the same for all of</p> <p>17 those patients or does it vary by, you know, individual</p> <p>18 patient?</p> <p>19 A. The basic screening is the same for all of</p> <p>20 them because they need to have a good exam, they need to</p> <p>21 have basic laboratory tests, and they need a good</p> <p>22 history, and I'm finding many of them aren't getting</p> <p>23 those things done in their general practices, in the</p> <p>24 primary practice because of very busy doctors, so I'll be</p>

<p style="text-align: right;">Page 122</p> <p>1 a little more -- I'll take longer, and I'll be a little</p> <p>2 more detailed, but everybody will get a basic screening.</p> <p>3 If there's anything discovered, then they would go on to</p> <p>4 get more unique tests done.</p> <p>5 Q. I'm sorry. I didn't hear the end of that</p> <p>6 answer. What was that you said, Doctor?</p> <p>7 A. They're all screened the same way. That's</p> <p>8 what I wanted to say.</p> <p>9 Q. Okay. And do -- after the basic screening</p> <p>10 that they all get the same way do some of those patients</p> <p>11 get additional screening based upon what you find after</p> <p>12 you do the basic screening?</p> <p>13 A. Yes.</p> <p>14 Q. Okay. And do they all get the same</p> <p>15 additional screening or does it vary by patient?</p> <p>16 A. It would vary by what the reason is for doing</p> <p>17 the additional screening.</p> <p>18 Q. Okay. Now I'm going to ask you a</p> <p>19 hypothetical. If one of those asymptomatic patients</p> <p>20 provided you information that they had -- they ate a lot</p> <p>21 of bacon or that they had taken Valsartan between 2012</p> <p>22 and 2018, would your screening of that patient change in</p> <p>23 any way?</p> <p>24 MS. GEMAN: Objection, incomplete</p>	<p style="text-align: right;">Page 124</p> <p>1 MS. GEMAN: Objection, asked and answered,</p> <p>2 incomplete hypothetical, vague.</p> <p>3 BY THE WITNESS:</p> <p>4 A. The Valsartan is not -- is not a deal -- a</p> <p>5 detail that I can answer to because the patients we're</p> <p>6 dealing with have levels that have been proven, have been</p> <p>7 identified to be in a class. You're talking about an</p> <p>8 individual person who's taking the drug. I wouldn't have</p> <p>9 any -- right now any -- a plan of how to specifically</p> <p>10 address that patient. They would need the same</p> <p>11 monitoring and the same -- I mean the same evaluation</p> <p>12 that the patients in the class have had to determine</p> <p>13 their level of -- of exposure, et cetera.</p> <p>14 BY MR. GEOPPINGER:</p> <p>15 Q. Would it be accurate to say you would treat</p> <p>16 that patient just like you do the asymptomatic patients</p> <p>17 you treat now?</p> <p>18 MS. GEMAN: Objection.</p> <p>19 BY THE WITNESS:</p> <p>20 A. Again, it depends on -- on the situation of</p> <p>21 the patient that I have in front of me. To take one</p> <p>22 patient is very difficult to answer. It's not a real</p> <p>23 patient.</p> <p>24</p>
<p style="text-align: right;">Page 123</p> <p>1 hypothetical, compound.</p> <p>2 BY THE WITNESS:</p> <p>3 A. It would depend. I'd have to be there with</p> <p>4 the patient and see -- hear everything about it. I can't</p> <p>5 answer that question with what you've told me.</p> <p>6 BY MR. GEOPPINGER:</p> <p>7 Q. Would it be accurate to say that you would</p> <p>8 make an individual determination about the screening in</p> <p>9 that case --</p> <p>10 MS. GEMAN: Objection.</p> <p>11 BY MR. GEOPPINGER:</p> <p>12 Q. -- for the patient?</p> <p>13 A. After the initial evaluation I would make an</p> <p>14 independent decision just like with any patient including</p> <p>15 Valsartan-exposed patients after they've gone through the</p> <p>16 screening I've recommended.</p> <p>17 Q. Okay. So in my hypothetical I have an</p> <p>18 asymptomatic patient who tells you that they have -- that</p> <p>19 they had foods in their diet that may include NDMA, that</p> <p>20 they may have been taking Valsartan-containing products</p> <p>21 from 2012 to 2018. In that situation, would your process</p> <p>22 for treating an asymptomatic patient be any different</p> <p>23 than it would be in treating the asymptomatic patients</p> <p>24 you see right now?</p>	<p style="text-align: right;">Page 125</p> <p>1 BY MR. GEOPPINGER:</p> <p>2 Q. Would you give -- would you recommend for</p> <p>3 that patient who reveals to you the -- their history of</p> <p>4 dietary intake of NDMA and potential history of VCB usage</p> <p>5 and NDMA, would you automatically screen them for all the</p> <p>6 conditions that you've listed in your report?</p> <p>7 MS. GEMAN: Objection, incomplete</p> <p>8 hypothetical.</p> <p>9 BY THE WITNESS:</p> <p>10 A. Just on the basis of that history I wouldn't</p> <p>11 necessarily do anything different than what we've already</p> <p>12 discussed.</p> <p>13 MR. GEOPPINGER: Thank you, Doctor. I don't</p> <p>14 have any further questions.</p> <p>15 MR. KERNER: Anyone else?</p> <p>16 MS. LOTMAN: If I may, Doctor. This is Alyson</p> <p>17 Lotman. I have one more question. I think it's just</p> <p>18 one.</p> <p>19 RE CROSS EXAMINATION</p> <p>20 BY MS. LOTMAN:</p> <p>21 Q. Who do you recommend to do these screenings?</p> <p>22 MS. GEMAN: Objection.</p> <p>23 BY THE WITNESS:</p> <p>24 A. I don't understand your question. Who do I</p>

<p style="text-align: right;">Page 126</p> <p>1 recommend?</p> <p>2 BY MS. LOTMAN:</p> <p>3 Q. If these -- if the patients were to get the</p> <p>4 screening that you recommended here, who should be</p> <p>5 administering it?</p> <p>6 A. Well, as I outlined in my report, it would be</p> <p>7 either the primary care doctor or an oncologist or a</p> <p>8 general practitioner, a family practitioner, somebody</p> <p>9 that would be made aware usually through the patient</p> <p>10 telling them that they have this exposure, this risk and</p> <p>11 they have this recommended guideline for screening.</p> <p>12 Q. And if their doctor decided that based upon</p> <p>13 their comorbidities or their medical history that these</p> <p>14 were unnecessary, do you believe that your plan should</p> <p>15 stand in place of that doctor's judgment?</p> <p>16 MS. GEMAN: Objection, incomplete</p> <p>17 hypothetical.</p> <p>18 BY THE WITNESS:</p> <p>19 A. My plan is a guideline, just like the NCCN</p> <p>20 has their guidelines, and it's up to the individual</p> <p>21 practitioner to -- to decide based on the individual</p> <p>22 patient what is appropriate for them.</p> <p>23 MS. LOTMAN: Thank you very much, Doctor.</p> <p>24 MS. GEMAN: Are there any other questions from</p>	<p style="text-align: right;">Page 128</p> <p>1 You're not recommending that this monitoring program be</p> <p>2 provided to people who did not take the contaminated</p> <p>3 Valsartan, i.e. you are not recommending this program to,</p> <p>4 this exact program to non-class members; correct?</p> <p>5 A. The point of this program was medical</p> <p>6 monitoring for those that had been identified as being at</p> <p>7 risk because of their intake of Valsartan-contaminated</p> <p>8 products.</p> <p>9 MS. GEMAN: Okay. Thank you for the</p> <p>10 clarification.</p> <p>11 Okay. We'd like to read and sign.</p> <p>12 MR. KERNER: Yeah.</p> <p>13 THE VIDEOGRAPHER: The time is now 12:33 p.m.</p> <p>14 This is the end of media six.</p> <p>15 This concludes this deposition. We're off</p> <p>16 the record.</p> <p>17 THE REPORTER: Would anyone like a copy of the</p> <p>18 transcript?</p> <p>19 MR. STOY: This is Frank Stoy. I'd like an</p> <p>20 electronic copy, please.</p> <p>21 MS. LOTMAN: Alyson Lotman. I'd like the</p> <p>22 same.</p> <p>23 MR. CHARCHALIS: (Inaudible).</p> <p>24 MS. ISIDRO: Mitchell wants an electronic.</p>
<p style="text-align: right;">Page 127</p> <p>1 the Defendants?</p> <p>2 (No response.)</p> <p>3 Do you have it on your screen? Did people</p> <p>4 write in?</p> <p>5 MS. ISIDRO: No one else on the Zoom?</p> <p>6 MS. GEMAN: Do you formally conclude it and</p> <p>7 pass it to me? How are we doing this?</p> <p>8 MR. KERNER: Yeah, if none of the Defendants</p> <p>9 have any questions and you have questions, ask away.</p> <p>10 MS. GEMAN: Thank you.</p> <p>11 CROSS EXAMINATION</p> <p>12 BY MS. GEMAN:</p> <p>13 Q. Dr. Kaplan, what is CLIA certification?</p> <p>14 A. CLIA certification is -- is certification</p> <p>15 that's given by a board that -- that attests to the</p> <p>16 accuracy and the usefulness of a particular test, that</p> <p>17 it's considered accurate and it does have some impact for</p> <p>18 the patient.</p> <p>19 Q. Okay. Can you please take out what's been</p> <p>20 marked as Exhibit 3 and turn to Page 3. Does the class</p> <p>21 as set forth on Page 3 capture the population of people</p> <p>22 for whom you are recommending your monitoring program?</p> <p>23 A. Yes.</p> <p>24 Q. I think there was some confusion before.</p>	<p style="text-align: right;">Page 129</p> <p>1 STATE OF ILLINOIS)</p> <p>2) SS:</p> <p>3 COUNTY OF C O O K)</p> <p>4 I, KELLY A. BRICHETTO, a Certified Shorthand</p> <p>5 Reporter of said state, do hereby certify</p> <p>6 that the within named witness, EDWARD H. KAPLAN, M.D.,</p> <p>7 was by me first duly sworn to testify the truth, the</p> <p>8 whole truth and nothing but the truth in the cause</p> <p>9 aforesaid; that the testimony then given by the</p> <p>10 above-referenced witness was by me reduced to stenotype</p> <p>11 in the presence of said witness; afterwards transcribed,</p> <p>12 and that the foregoing is a true and correct</p> <p>13 transcription of the testimony so given by the</p> <p>14 above-referenced witness.</p> <p>15 I do further certify that this deposition was</p> <p>16 taken at the time and place in the foregoing caption</p> <p>17 specified and was completed without adjournment.</p> <p>18 I do further certify that I am not a relative,</p> <p>19 counsel or attorney for either party or otherwise</p> <p>20 interested in the event of this action.</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>

<p style="text-align: right;">Page 130</p> <p>1 IN WITNESS WHEREOF, I do hereunto set my hand</p> <p>2 this 21st day of January, 2022.</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7 <i>Kelly Brichetto</i></p> <p>8 KELLY A. BRICHETTO</p> <p>9 CSR License No. 84-3252</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>	<p style="text-align: right;">Page 132</p> <p>1 In Re: Valsartan, Losartan, Et Al v.</p> <p>2 Edward H Kaplan , MD (#5025121)</p> <p>3 E R R A T A S H E E T</p> <p>4 PAGE_____ LINE_____ CHANGE_____</p> <p>5 _____</p> <p>6 REASON_____</p> <p>7 PAGE_____ LINE_____ CHANGE_____</p> <p>8 _____</p> <p>9 REASON_____</p> <p>10 PAGE_____ LINE_____ CHANGE_____</p> <p>11 _____</p> <p>12 REASON_____</p> <p>13 PAGE_____ LINE_____ CHANGE_____</p> <p>14 _____</p> <p>15 REASON_____</p> <p>16 PAGE_____ LINE_____ CHANGE_____</p> <p>17 _____</p> <p>18 REASON_____</p> <p>19 PAGE_____ LINE_____ CHANGE_____</p> <p>20 _____</p> <p>21 REASON_____</p> <p>22 _____</p> <p>23 _____</p> <p>24 Edward H Kaplan , MD Date</p>
<p style="text-align: right;">Page 131</p> <p>1 RACHEL J. GEMAN</p> <p>2 rgeman@lchb.com</p> <p>3 January 26, 2022</p> <p>4 RE: In Re: Valsartan, Losartan, Et Al</p> <p>5 1/19/2022, Edward H Kaplan , MD (#5025121)</p> <p>6 The above-referenced transcript is available for</p> <p>7 review.</p> <p>8 Within the applicable timeframe, the witness should</p> <p>9 read the testimony to verify its accuracy. If there are</p> <p>10 any changes, the witness should note those with the</p> <p>11 reason, on the attached Errata Sheet.</p> <p>12 The witness should sign the Acknowledgment of</p> <p>13 Deponent and Errata and return to the deposing attorney.</p> <p>14 Copies should be sent to all counsel, and to Veritext at</p> <p>15 erratas-cs@veritext.com</p> <p>16</p> <p>17 Return completed errata within 30 days from</p> <p>18 receipt of testimony.</p> <p>19 If the witness fails to do so within the time</p> <p>20 allotted, the transcript may be used as if signed.</p> <p>21</p> <p>22 Yours,</p> <p>23 Veritext Legal Solutions</p> <p>24</p>	<p style="text-align: right;">Page 133</p> <p>1 In Re: Valsartan, Losartan, Et Al v.</p> <p>2 Edward H Kaplan , MD (#5025121)</p> <p>3 ACKNOWLEDGEMENT OF DEPONENT</p> <p>4 I, Edward H Kaplan , MD, do hereby declare that I</p> <p>5 have read the foregoing transcript, I have made any</p> <p>6 corrections, additions, or changes I deemed necessary as</p> <p>7 noted above to be appended hereto, and that the same is</p> <p>8 a true, correct and complete transcript of the testimony</p> <p>9 given by me.</p> <p>10</p> <p>11 _____</p> <p>12 Edward H Kaplan , MD Date</p> <p>13 *If notary is required</p> <p>14 SUBSCRIBED AND SWORN TO BEFORE ME THIS</p> <p>15 _____ DAY OF _____, 20____.</p> <p>16</p> <p>17</p> <p>18 _____</p> <p>19 NOTARY PUBLIC</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p>

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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